October 1, 2002

TO: All Dental Providers

FROM: Carree Moore, Dental Program Manager
Medical Assistance Administration
Department of Social and Health Services

Enclosed are updated Washington State Medical Assistance Dental Program Billing Instructions, dated November 2002. This revision incorporates policy changes spelled out in the Washington Administrative Code (WAC). Chapter 388-535A (Orthodontics) WAC was adopted in January 2002 and Chapter 388-535 WAC (Dental-Related Services) was adopted in July 2002.

Due to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), many of the state-unique dental procedure codes have been eliminated. These codes have been replaced with equivalent codes in the American Dental Association's (ADA) Current Dental Terminology-3 (CDT-3) coding structure. Where necessary, the Medical Assistance Administration (MAA) includes additional language clarifying Washington-specific program limitations (e.g., for purposes of the Dental Program, the state defines a child as up to age 18, while the federal definition of a child is up to age 21). Please carefully review these billing instructions for all the services you normally bill to MAA as the changes are too numerous to list.

Rate increases have been targeted to selected procedures for the past three years. Refer to Numbered Memorandum 02-56 MAA for details regarding the July 2002 dental rate increases. Go to: http://maa.dshs.wa.gov [Click on "Provider Publications/Fee Schedules," then open Numbered Memorandums].

Thank you for the services you provide to Medical Assistance clients. If you have any questions, please refer to the Important Contacts section of the billing instructions.

Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

DENTAL & ORTHODONTIC PROGRAMS

Billing Instructions
(WAC 388-535)

November 2002

Copyright Disclosure

About this publication

This publication supersedes all previous MAA Dental Billing Instructions and the following Numbered Memoranda:

00-70 MAA, 01-07 MAA, 01-49 MAA, 02-56 MAA

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Orthodontics Table of Contents (last section)

Important Contacts

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment
Toll-Free (866) 545-0544

Where do I send my dental bills?

Hard Copy Billing:
Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Magnetic Tapes/Floppy Disks Billing:
Division of Program Support
PO Box 45560
Olympia, WA 98504-5560

Electronic Billing:
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Who do I call to request free in-office provider training?

Field Services Unit
(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

Where do I call if I have questions on…

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Internet billing?

http://maa.dshs.wa.gov
[Open the "Electronic Claims Submission" link in left hand Table of Contents]

Where do I write to get prior authorization?

Quality Utilization Section-Dental
PO Box 45506
Olympia WA 98504-5506

For procedures that do not require X-Rays - Fax: (360) 586-5299

Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

Go to MAA's website at:
http://maa.dshs.wa.gov
Click on "Provider Publications/Fee Schedules."

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Definitions

This section contains definitions of words and phrases that the Department of Social and Health Services (DSHS) uses in these billing instructions. MAA also used dental definitions found in the American Dental Association's Current Dental Terminology (CDT 3) and the American Medical Association's Physician's Current Procedural Terminology 2002 (CPT 2002). **Where there is any discrepancy between the CDT 3 or CPT 2002 and this section, this section prevails.**

Adult – For the general purposes of MAA's dental program, means a client 21 years of age and older. (MAA's payment structure changes at age 19, which affects specific program services provided to adults or children). [WAC 388-535-1050]

American Dental Association (ADA) – The ADA is a national organization for dental professionals/dental societies.

Anterior – Teeth in the front of the mouth. Specifically only these permanent teeth: 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 and these primary teeth: C, D, E, F, G, H, M, N, O, P, Q, and R.

Asymtomatic – Having or producing no symptoms. [WAC 388-535-1050]

Authorization - An official approval for action taken for or on behalf of an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by the Medical Assistance Administration (MAA) that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base Metal – Dental alloy containing little or no precious metals. [WAC 388-535-1050]

Behavior Management – Managing the behavior of a client during treatment using the assistance of additional professional staff, and professionally accepted restraints or sedative agent, to protect the client from self-injury. [WAC 388-535-1050]

By Report (BR) – A method of payment for a covered service, supply or equipment which:

- Has no maximum allowable established by MAA;
- Is a variation on a standard practice; or
- Is rarely provided.

[WAC 388-535-1050]

Caries – Tooth decay through the enamel. [WAC 388-535-1050]

Child –For the general purposes of the MAA Dental Program, means a client 20 years of age or younger. (MAA's payment structure changes at age 19, which affects specific program services provided to adults or children). [WAC 388-535-1050]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - Field offices of the Department of Social and Health Services located in communities throughout the state which administer various services of the department at the community level.

Comprehensive Oral Evaluation – A thorough evaluation and recording of the hard and soft tissue in and around the mouth, including the evaluation and recording of the client's dental and medical history and a general health assessment. [WAC 388-535-1050]

Conscious sedation – Is a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and/or verbal command, produced by a pharmacologic method, and that carries a margin of safety wide enough to render unintended loss of protective reflexes unlikely. [WAC 246-817-710 Dental Quality Assurance Commission]

Conscious sedation with oral agent – Includes the administration or prescription for a single oral sedative agent used alone or in combination with nitrous oxide sedation. [WAC 246-817-750 Dental Quality Assurance Commission]

Core Provider Agreement - A basic contract that MAA holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Coronal – The portion of a tooth that is covered by enamel, and is separated from the root or roots by a slightly constricted region, known as the cemento-enamel junction. [WAC 388-535-1050]

Crown (artificial) – A restoration covering or replacing the major part, or the whole of, the clinical crown of a tooth. [WAC 388-535-1050]

Current Dental Terminology, third edition (CDT 3) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA). [WAC 388-535-1050]

[CDT is used for the majority of the procedure codes used by MAA in this Billing Instructions.]

Current Procedural Terminology (CPT™) – A description of medical procedures and is available from the American Medical Association of Chicago, Illinois. [WAC 388-535-1050]

Dentures – A set of artificial teeth including overdentures. [WAC 388-535-1050]

Department - The state Department of Social and Health Services.

Division of Developmental Disabilities (DDD) - The division within DSHS responsible for administering and overseeing services and programs for clients with developmental disabilities.

Endodontic – A root canal treatment and related follow-up. [WAC 388-535-1050]

EPSDT – The department's early and periodic screening, diagnosis, and treatment program for client's 20 years of age and younger as described in chapter 388-534 WAC. [WAC 388-535-1050]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Fluoride Varnish or gel – A substance containing dental fluoride, applied to teeth. [WAC 388-535-1050]

General anesthesia – (to include deep sedation) is a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof. [WAC 246-817-710 Dental Quality Assurance Commission]

High noble metal – Dental alloy containing at least 60% pure gold. [WAC 388-535-1050]

Limited oral evaluation – An evaluation limited to a specific oral health condition or problem. [WAC 388-535-1050]

Major bone grafts – A transplant of solid bone tissue(s). [WAC 388-535-1050]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. Also known as Title XIX.

Medical Assistance Administration (MAA) - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification (ID) card – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

b) "Part B" is the supplementary medical insurance benefits (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other services and supplies not covered under Medicare Part A. [WAC 388-500-0005]

Minor bone grafts – A transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.
[WAC 388-535-1050]

Noble metal – A dental alloy containing at least 25% but less than 60% pure gold.
[WAC 388-535-1050]

Oral Evaluation – A comprehensive oral health and development history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance. [WAC 388-535-1050]

Oral health assessment or screening – A screening of the hard and soft tissues in the mouth. [WAC 388-535-1050]

Oral hygiene instruction – Instruction for home oral hygiene care, such as tooth brushing techniques or flossing.
[WAC 388-535-1050]

Oral health status – Refers to the client's risk or susceptibility to dental disease at the time an oral evaluation or assessment is done by a dental practitioner.
[WAC 388-535-1050]

Partials or partial dentures – A removable appliance replacing one or more missing teeth in the jaw, and receiving its support and retention from both the underlying tissues and some or all of the remaining teeth. [WAC 388-535-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name (and spaces if the name is fewer than five letters); and
d) Alpha or numeric character (tiebreaker).

Posterior – Teeth and tissue towards the back of the mouth. Specifically, only these permanent teeth: 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 and these primary teeth: A, B, I, J, K, L, S, T.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical [dental] care, goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Reline – To resurface the tissue side of a denture with new base material in order to achieve a more accurate fit. [WAC 388-535-1050]

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Root Planing – A procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin from the teeth's root surfaces and pockets. [WAC 388-535-1050]

Scaling – The removal of calculus material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva. [WAC 388-535-1050]

Sealant – A material applied to teeth to prevent dental caries. [WAC 388-535-1050]

Spenddown – The amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirements.

State Unique Procedure Code(s) – MAA procedure code(s) used for a specific service(s) where there is not an ADA-CDT or CPT procedure code available or appropriate.

Symptomatic – Having symptoms (e.g., pain, swelling, and infection). [WAC 388-535-1050]

Therapeutic pulpotomy – The surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp. [WAC 388-535-1050]

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA. [WAC 388-535-1050]

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Wisdom Teeth – Teeth 1, 16, 17, and 32.

Xerostomia – A dryness of the mouth. [WAC 388-535-1050]

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Dental Program

What is the purpose of the Dental Program?

The purpose of the Dental Program is to provide high quality, covered dental and dental-related services to eligible clients.

Becoming a DSHS dental provider [Refer to WAC 388-535-1070(1)]

The following providers are eligible to enroll with the Medical Assistance Administration (MAA) to furnish and bill for dental-related services to eligible clients:

- Persons currently licensed by the state of Washington to:
  - ✓ Practice dentistry or specialties of dentistry (e.g., orthodontics);
  - ✓ Practice medicine and osteopathy for:
    - ➢ oral surgery procedures; or
    - ➢ providing fluoride varnish under EPSDT
  - ✓ Practice as a dental hygienist;
  - ✓ Practice as a denturist;
  - ✓ Provide conscious sedation, when certified by the Department of Health with the appropriate permit on file with MAA;
  - ✓ Provide general anesthesia (including deep sedation), when certified by the Department of Health with the appropriate permit on file with MAA.
- Facilities that are:
  - ✓ Hospitals currently licensed by the Department of Health;
  - ✓ Federally-qualified health centers (FQHCs);
  - ✓ Medicare-certified ambulatory surgical centers (ASCs);
  - ✓ Medicare-certified rural health clinics (RHCs); or
  - ✓ Community health centers (CHC).
- Participating local health jurisdictions; and
- Border area or out-of-state providers of dental-related services who are qualified in their states to provide these services.

☞ **Note: MAA pays licensed providers participating in the MAA dental program for only those services that are within their scope of practice. [WAC 388-535-1070(2)]**

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Client Eligibility

Who is eligible? [Refer to WAC 388-535-1060]

Clients presenting DSHS Medical Identification cards with the following medical program identifiers are eligible for covered dental services listed in the dental fee schedule:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-QMB	CNP-Qualified Medicare Beneficiary
LCP-MNP	Limited Casualty Program/ Medically Needy Program
MNP-QMB	Medically Needy Program - QMB

Clients eligible for limited services:

[Refer to WAC 388-535-1120(1)]

Clients with the following identifiers on their Medical ID cards are covered for **ONLY** those services listed on pages D7-D8.

- **GAU – No out of state care** (General Assistance – Unemployable)
- **W – No out of state care** (Alcoholism & Drug Addiction Treatment and Support Act)

Clients with the following identifier on their Medical ID cards are covered for **ONLY** those medical conditions that are acute and emergent and treated in a hospital:

- **Emergency Hospital and Ambulance Only** (Medically Indigent Program)

These emergency services **do not** require prior authorization. No other places of service are covered for clients with the Medically Indigent Program identifier.

☞ **Note:** **To provide clarification as a result of significant inquiries, clients presenting Medical Identification cards with the following identifiers <u>are not eligible</u> for dental services listed in the dental fee schedule:**

- **Family Planning Only (see page F3)**
- **TAKE CHARGE**
- **QMB – Medicare Only** (Receive funding for Medicare premium only)

Are Healthy Options managed care clients eligible for services under MAA's Dental Program?

[Refer to WAC 388-535-1060(3)]

Yes! Clients who are enrolled in a medical managed care plan are eligible for MAA-covered dental services that are not covered by their plan, under fee-for-service.

Clients who are enrolled in a Healthy Options medical managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column on their Medical ID card.

Clients eligible for enhanced services

Clients of the Division of Developmental Disabilities (DDD) may be entitled to more frequent services. See page D5.

These individuals will have an "XX" in the "DD" column of their Medical ID card. Individuals lacking the DD information on their Medical ID card are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient's guardian to the nearest Developmental Disabilities Office (see list below).

Division of Developmental Disabilities Field Offices

Region 1
1611 West Indiana Ave
MS: B32-28
Spokane WA 99205-4221
(509) 456-2893
(509) 456-4256 FAX
1-800-462-0624

Region 2
1002 N. 16th Avenue
MS: B39-7
Yakima WA 98909-2500
(509) 225-7970
(509) 575-2326 FAX
1-800-822-7840

Region 3
840 N. Broadway
Building A, Suite 100
MS: N31-11
Everett, WA 98201-1296
(425) 339-4833
(425) 339-4856 FAX
1-800-788-2053

Region 4
1700 East Cherry Street
MS: N46-6
Seattle WA 98122-4695
(206) 568-5700
(206) 720-3334 FAX
1-800-314-3296

Region 5
1305 Tacoma Avenue S., Suite 300
MS: N27-6
Tacoma WA 98402
(253) 593-2812
(253) 597-4368 FAX
1-800-248-0949

Region 6
Airdustrial Park, Bldg. 6
MS: 45315
PO Box 45315
Olympia, WA 98504-5315
(360) 753-4673
(360) 586-6502 FAX
1-800-339-8227

If you have any problems contacting these field offices, call Connie Mix-Clark DDD state office, at (360) 902-8475.

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Coverage

When does MAA pay for covered dental-related services?

[Refer to WAC 388-535-1080(1)]

MAA pays for covered dental and dental-related services listed in this section **only** when they are:

a) Within the scope of the eligible client's medical care program;
b) Medically necessary; and
c) Within accepted dental or medical practice standards and are:

   i. Consistent with a diagnosis of dental disease or condition; and
   ii. Reasonable in amount and duration of care, treatment, or service.

Items and services are subject to the specific limitations listed in the fee schedule, see Section H.

What is covered – general?

[Refer to WAC 388-535-1080(2)]

MAA covers the following dental-related services:

a) Medically necessary services for the identification of dental problems or the prevention of dental disease (subject to the limitations in these billing instructions).

b) **Oral health evaluations and assessments**, which must be documented in the client's file according to WAC 388-502-0020, as follows:

   i. MAA allows a **comprehensive oral evaluation** once per provider as an initial examination, and it must include:

      A. An oral health and developmental history;
      B. An assessment of physical and oral health status;
      C. Health education, including anticipatory guidance; and
      D. Treatment plan.

   ii. MAA allows **periodic oral evaluations** once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

iii. MAA allows **limited oral evaluations** only when the provider performing the limited oral evaluation is not providing pre-scheduled dental services for the client. The limited oral evaluation must provide:

A. Limited or emergent services for a specific dental problem; or
B. An evaluation for a referral.

c) **Radiographs** (x-rays) for children and adults, as follows:

i. Intraoral (complete series, including bitewings) – once in a three-year period;
ii. Bitewings – total of four every twelve months;
iii. Panoramic, **for oral surgical purposes only**, as follows:

A. Not allowed with an intraoral complete series; and
B. Once in a three-year period, except for preoperative or postoperative surgery cases. Preoperative x-rays must be provided within 14 days prior to surgery, and postoperative x-rays must be provided within 30 days after surgery.

d) **Fluoride treatment** (gel or varnish) as follows (additional applications require prior authorization):

i. For children through age 18, topical application of fluoride varnish or gel, up to three times in a 12-month period.

ii. For adults age 19 through 64, topical application of fluoride gel or varnish for xerostomia only; this requires prior authorization. See page H10 for clients of the Division of Developmental Disabilities.
iii. For adults age 65 and older, topical application of fluoride gel or varnish for only:

A. Rampant root surface decay; or
B. Xerostomia (reduced salivary flow).

e) **Sealants for children only**, once per tooth in a three-year period for:

i. The occlusal surfaces of:

A. Permanent teeth 2, 3, 14, 15, 18, 19, 30, and 31 only; and
B. Primary teeth A, B, I, J, K, L, S, and T only.

ii. The lingual pits of teeth 7 and 10; and
iii. Teeth with no decay.

f) **Prophylaxis treatment,** which is allowed:

i. Once every 12 months for adults age 19 and older, including nursing facility clients.
ii. Once every 6 months for children age 8 through 18.
iii. Only as a component of oral hygiene instruction for children through age 7.
iv. Three times per calendar year for clients of the Division of Developmental Disabilities (see page D5).

g) **Space maintainers**, for children through age 18 only as follows:

i. Fixed (unilateral type), one per quadrant;
ii. Fixed (bilateral type), one per arch; and
iii. Recementation of space maintainer, once per quadrant or arch.

h) **Amalgam or composite restorations** once in a two-year period for the same surface of the same tooth.

i) **Crowns**, see page H14.

j) **Restoration of teeth and maintenance of dental health**, subject to limitations in "What dental-related services are not covered" (see page D9) and as follows:

i. Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration, and are reimbursed as such; and
ii. Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a two-surface restoration, and are reimbursed as such.

k) **Endodontic (root canal) therapies for permanent teeth only** except for wisdom teeth.

l) **Therapeutic pulpotomies**, once per tooth, on primary teeth only.

m) **Pulp vitality test**, as follows:

i. Once per day (not per tooth);
ii. For diagnosis of emergency conditions only; and
iii. Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.

n) **Periodontal scaling and root planing**, as follows:

i. For clients age 19 and older only. (See D5 for clients of the Division of Developmental Disabilities.)
ii. Only when the client has radiographic (x-ray) evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis.
iii. Once per quadrant in a 24-month period; and
iv. Not allowed when performed on the same date of service as adult prophylaxis or gingivectomy.

o) **Complete and partial dentures**, and necessary modifications, repairs, rebasing, relining, and adjustments of dentures (includes partial payment in certain situations for laboratory and professional fees for dentures and partials). See Dentures, page H21.

MAA covers:

i. One set of dentures per client in a 10-year period, with the exception of replacement dentures which may be allowed as specified under Dentures (page H21); and
ii. Partials, as specified in the Denture section, once every five years.

p) **Complex orthodontic treatment** for severe handicapping dental needs as specified under Orthodontics (see Orthodontics section at end of billing instructions).

q) **Occlusal orthotic device** for management of temporomandibular joint dysfunction (TMJ), one in a two-year period.

r) **Medically necessary oral surgery** when coordinated with the client's managed care plan (if any).

s) **Dental services or treatment necessary for the relief of pain and infections**, including removal of symptomatic wisdom teeth. MAA does not cover routine removal of asymptomatic wisdom teeth.

t) **Behavior management for children through age 18 only**, whose documented behavior requires the assistance of more than one additional dental professional staff to protect the client from self-injury during treatment. (See page D5 for clients of the Division of Developmental Disabilities.)

u) **Nitrous oxide for children through age 18 only**, when medically necessary. (See page D5 for clients of the Division of Developmental Disabilities).

v) **Professional visits**, as follows:

   i. Bedside call, nursing facility or residence, at the request of a physician (ADA procedure code D9410) is allowed once per day, per provider regardless of the number of clients seen.
   ii. Hospital call, including emergency care is allowed once per day, per client.

w) **Emergency palliative treatment**, as follows:

   i. Allowed only when no other definitive treatment is performed on the same day; and
   ii. Documentation must include tooth designation and a brief description of the service.

What additional dental-related services are covered for DDD clients? [Refer to WAC 388-535-1080(3)]

For clients of the Division of Developmental Disabilities, MAA allows the following additional services:

a) Periodontal scaling and root planing – once every six months;
b) Prophylaxis – three times per calendar year;
c) Nitrous oxide;
d) Behavior management that requires the assistance of more than one additional dental professional staff and the use of advanced behavior management techniques; and
e) Panoramic radiographs, with documentation that behavior management is required.

What dental-related services are covered when provided in a hospital? [Refer to WAC 388-535-1080(4)]

MAA covers medically necessary services provided in a hospital under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization; and
b) Short stays when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page D9.)

When is anesthesia covered under MAA's Dental Program?

[Refer to WAC 388-535-1080(5)]

MAA covers general anesthesia (including deep sedation) when:

i) The service is medically necessary; and
ii) Justification for administering general anesthesia, instead of a lesser type of sedation, is clearly documented in the client's file.

-AND-

iii) One of the following:

- Provider administering general anesthesia is a Certified Registered Nurse Anesthetist (CRNA); or
- Provider has a current general anesthesia permit from the Department of Health (DOH) on file with MAA; or
- Provider is an anesthesiologist.

MAA covers conscious sedation (with parenteral or multiple oral agents) when:

i) The service is medically necessary; and
ii) Provider has a current conscious sedation permit from DOH on file with MAA.

What dental-related services are covered for clients residing in nursing facilities or group homes?

[Refer to WAC 388-535-1080(6)]

For clients residing in nursing facilities or group homes:

a) Dental services must be requested by the client or a referral for services made by:

- the attending physician;
- the director of nursing or the nursing facility supervisor; or
- the client's legal guardian.

b) Mass screening for dental services of clients residing in a nursing facility is not permitted; and
c) Nursing facilities must provide dental-related necessary services per WAC 388-97-012 (Nursing facility care).

What are the coverage limits for dental-related services provided under state-only funded programs?

[Refer to WAC 388-535-1120]

As stated on page C1, under "Clients eligible for limited services," clients who receive services under the following state-only funded programs receive only the limited coverage described below:

a) General assistance unemployable (GAU); and
b) Alcohol and drug abuse treatment and support act (ADATSA) (GAU-W).

MAA covers the dental services described and limited in this billing instruction and under chapter 388-535 WAC for clients eligible for GAU or GAU-W only when those services are provided as part of a medical treatment for:

a) Apical abscess verified by clinical examination, and treated by:

    i. Open and drain palliative treatment;
    ii. Tooth extraction; or
    iii. Root canal.

b) Cysts or tumor therapies;

c) Maxillofacial fracture;

d) Radiation therapy for cancer of the mouth, covered only for a total dental extraction performed prior to and because of radiation therapy;

e) Sequestrectomies;

f) Systemic or presystemic cancer, only for oral hygiene related to those conditions; or

g) Tooth fractures (limited to extraction).

See next page for list of procedure codes covered under this program.

GAU/GAU-W Covered Procedure Codes :

ADA	D5610	11643	21041	40806
D0140	D5630	11644	21044	40808
D0210	D5640	11646	21045	40819
D0220	0565D	12001	21076	40831
D0230	D5650	12002	21077	41000
D0240	D5660	12004	21141	41005
D0330	D5710	12005	21142	41006
D0460	D5711	12011	21143	41007
D0501	D5720	12013	21336	41008
D7110	D5721	12015	21337	41009
D7120	D5750	12016	21344	41010
D7130	D5751	12031	21346	41015
D7210	D5760	12032	21347	41016
D7220	D5761	12034	21348	41017
D7230	D5850	12035	21355	41018
D7240	D5851	12051	21356	41108
D7241	D5932	12052	21360	41825
D7250	D5952	12053	21365	41827
D3310	D9110	12054	21366	41830
D3320	D9220	12055	21385	41874
D3330	D9610	13131	21406	42106
D3410	D9630	13132	21407	42180
D5110		13133	21408	42182
D5120	**CPT**	13150	21421	42200
0515D	11044	13151	21422	42205
D5211	11100	13152	21423	42210
D5212	11101	13153	21436	42220
D5213	11440	13160	21445	42225
D5214	11441	14040	21453	42227
D5410	11442	20220	21462	42235
D5411	11443	20520	21470	42280
D5421	11444	21030	21480	42281
D5422	11446	21031	21550	
D5510	11640	21032	30580	
D5520	11641	21034	40800	
0552D	11642	21040	40801	

See Section H – Dental Fee Schedule for Maximum Allowables, Limitations, and Required Documentation

Billing Procedures

1. The major procedure and all ancillary services must be billed as one treatment plan. Ancillary services will not be considered separately.

2. MAA may require reports and/or X-rays to make an authorization determination. In your request for prior authorization, be sure to include a written justification in *field 61* of the ADA claim form. Remember to mark any X-rays you send with your name and provider number.

   For detailed instructions on how to complete an **ADA claim form**, refer to Section G.

3. Submit the original claim *(make sure the client's PIC is on the claim)*, and any necessary authorization documentation. When MAA returns the original to you, look at the Dental Consultant section for the authorization number and any pertinent comments by the Dental Consultant.

What dental-related services are not covered?

[Refer to WAC 388-535-1100(1)(2)]

MAA does not cover the following dental-related services unless the services are:

a) Required by a physician as a result of an EPSDT screen as provided under chapter 388-534 WAC (orthodontic limitations still apply and services must be medically necessary);
b) Included in an MAA-waivered program; or
c) Part of one of the Medicare programs for Qualified Medicare Beneficiaries (QMB), except for QMB-only, which is not covered.

MAA does **not cover**:

a) **Any services specifically excluded by statute**.

b) **More costly services** when less costly, equally effective services as determined by the department are available.

c) Services, procedures, treatments, devices, drugs, or application of associated services which the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration [HCFA]) consider **investigative or experimental** on the date the services were provided.

d) **Routine fluoride treatments (gel or varnish) for adults**, unless the clients are:

i. Clients of the Division of Developmental Disabilities;
ii. Diagnosed with xerostomia, in which case the provider must request prior authorization; or
iii. High-risk adults, 65 years of age and older. High-risk means the client has at least one of the following:

A. Rampant root surface decay; or
B. Xerostomia.

e) **Crowns**, **as follows**:

i. For wisdom and peg teeth
ii. Laboratory processed crowns for posterior teeth
iii. Temporary crowns including stainless steel crowns placed as temporary crowns; and
iv. Post and core for crowns.

f) **Root canal services** for primary teeth or wisdom teeth;

g) **Root planing for children**, unless they are clients of the Division of Developmental Disabilities;

h) **Bridges**;

i) **Transitional or treatment dentures**;

j) **Teeth implants**, including follow-up and maintenance;

k) **Cosmetic treatment or surgery**, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

l) **Porcelain margin extensions** (also known as crown lengthening), due to receding gums;

m) **Extraction of asymptomatic teeth**;

n) **Minor bone grafts**;

☞ **Note:** Major bone grafts are not a replacement for minor bone grafts (e.g., major bone grafts in conjunction with extraction of wisdom teeth.).

o) **Nonemergent oral surgery for adults** performed in an inpatient setting, except for the following:

i. For clients of the Division of Developmental Disabilities, or for children 18 years of age or younger whose surgeries cannot be performed in an office setting. This requires written prior authorization for the inpatient hospitalization; or
ii. As provided in WAC 388-535-1080(4).

p) **Dental supplies** such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

q) **Dentist's time** writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

r) **Educational supplies**;

s) **Missed or cancelled appointments**;

t) **Nonmedical equipment**, supplies, personal or comfort items or services;

u) **Provider mileage** or travel costs;

v) **Service charges** or delinquent payment fees;

w) **Supplies used in conjunction with an office visit**;

x) **Take-home drugs**;

y) **Teeth whitening**; or

z) **Restorations for anterior or posterior wear** with no evidence of decay.

MAA evaluates a request for any service that is listed as noncovered, under the provisions of WAC 388-501-0165.

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Authorization

Authorization is based on the establishment of medical necessity. When prior authorization is required for a service, MAA considers these requests on a case-by-case basis.

When MAA authorizes a service, the authorization indicates only the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for covered services at the time those services are provided. [WAC 388-535-1220]

When do I need to get prior authorization?

Authorization must take place before the service is provided.

In an acute emergency, the department *may* authorize the service after it is provided when the department receives justification of medical necessity. This justification must be received by MAA within 72 hours of the emergency service or the next Washington State government business day.

Which services require prior authorization?

[Refer to WAC 388-535-1220]

The following services require prior authorization:

1) Non-emergent inpatient hospital dental admissions;
2) Crowns (see page H14);
3) Dentures (see page H21);
4) Routine fluoride treatment (gel or varnish) for adults age 19 through 64 years of age who are diagnosed with xerostomia; and
5) Selected procedures identified by MAA (see Section H – Dental Fee Schedule)

   The Dental Fee Schedule indicates which services require prior authorization.
   In the Prior Authorization column:

No	=	Prior Authorization for these services is not required. However, the service must be provided in accordance with the policies indicated for each procedure.
Yes	=	Prior Authorization is required for these services.

How do I obtain written prior authorization?

[Refer to WAC 388-535-1220]

MAA requires a dental provider who is requesting prior authorization to submit sufficient, objective, clinical information to establish medical necessity.

The request must be submitted in writing on a completed ADA Claim Form and include the following:

- The client's patient identification code (PIC);
- Provider's name and address;
- Provider's telephone number (including area code); and
- Provider's assigned 7-digit MAA provider number.
- Physiological description of the disease, injury, impairment, or other ailment;

Also:

- Appropriate, most recent X-ray(s) - If x-rays are requested or required, make sure they are identified with your name and provider number, so they can be returned to you.
- Treatment plan;
- Study model (if requested); and
- Photographs (if requested).

(Refer to Section G, How to Complete the ADA Claim Form.)

If MAA approves your request, the ADA Dental Claim Form will be returned to you with an authorization number. **This original form** is to be completed and submitted for payment. Keep a copy for your records.

Where should I send requests for prior authorization?

Mail your request to:

Quality Utilization Section - Dental
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require X-Rays
Fax: (360) 586-5299

Exceeding Limitations or Restrictions

A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. MAA evaluates and approves requests for LE for dental-related services when medically necessary, under the provisions of WAC 388-501-0165.

[WAC 388-535-1080(7)]

When does MAA deny requests for prior authorization?

[Refer to WAC 388-535-1220(3)]

MAA denies a request for dental services when the requested service is:

a) Not medically necessary;
b) Not covered by MAA; or
c) A service, procedure, treatment, device, drug, or application of associated service that the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)) considers investigative or experimental on the date the service is provided.

MAA may require second opinions and/or consultations before authorizing any procedure.

MAA requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. WAC 388-535-1220(1)

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- ✓ MAA requires providers to bill known third parties for services. See page F6 and/or WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

Refer to MAA's General Information Booklet, Section K, for instructions on how to correct any billing problems you experience (e.g., Adjustments/Rebillings).

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary charge.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

How do I bill for clients eligible for both Medicare and Medicaid?

Medicare does not cover dental procedures. **Surgical** CPT procedure codes 10000-69999 must be billed to Medicare first. After receiving Medicare's determination, submit a claim to MAA. Attach a copy of the Medicare determination.

When can I bill an MAA client? [Refer to WAC 388-502-0160]

1. A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.

2. The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

3. A provider may bill a client only if one of the following situations apply:

    a. The client is enrolled in medical assistance managed care and the client and provider comply with the requirements outlined in WAC 388-538-095, "Scope of care for managed care enrollees;"

    b. The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request.

        The agreement must include each of the following elements to be valid:

        i. A statement listing the specific service to be provided;
        ii. A statement that the service is not covered by MAA;
        iii. A statement that the client chooses to receive and pay for the specific service; and
        iv. The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.

    c. The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

d. The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA. [Medical Assistance is not insurance.];

e. The provider has documentation that the client represented himself/herself as a private pay patient and not receiving Medical Assistance when the client is already eligible for and receiving benefits under an MAA medical program. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection 3.b. regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection 4 of this section for that service.

f. The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA;

g. The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a $3.00 copayment may be imposed on the client by the hospital, except when:

i. Reasonable alternative access to care was not available;
ii. The "indigent person" criteria in WAC 246-453-040(1) applies;
iii. The client was 18 years of age or younger;
iv. The client was pregnant or within 60 days postpregnancy;
v. The client is an American Indian or Alaska Native;
vi. The client was enrolled in a MAA managed care plan, including Primary Care Case Management (PCCM);
vii. The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
viii. The client receives services under a waivered program such as community options program entry system (COPES) and community alternatives program (CAP).

4. If a client becomes eligible for a covered service that has already been provided because the client:

   a. Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

      i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
      ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;

   b. Receives a delayed certification (see footer on page F1), the provider must:

      i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
      ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

> ☞ **Note:** Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.
>
> If eligible, the client receives a DSHS Medical ID card dated the first of the month of application. The Medical ID card is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

   c. Receives a retroactive certification (see footer on page F2), the provider:

      i. Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
      ii. May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

5. Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described in subsection 3.g. of this section.

6. A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

   This includes, but is not limited to:

   (a) Medical charts;
   (b) Radiological or imaging films; and
   (c) Laboratory or other diagnostic test results.

Third-Party Liability

For dental services for children and pregnant women, you may elect to bill MAA directly and MAA will recoup from the third party. If you know the third party carrier, you may choose to bill them directly. The client may not be billed for co-pays.

For all medical claims, you must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier code information is available on the DSHS-MAA web site at http://maa.dshs.wa.gov. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to MAA's web site, call 1-800-562-6136 and request that a hard copy or disk be mailed to you.

What general records must be kept in a client's record?:

[Refer to WAC 388-502- 0020]
Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

  MAA does not pay for the copying or otherwise transferring health care information to another health care provider. This includes, but it not limited to, medical charts, radiological or imaging films, and laboratory or other diagnostic test results. [Refer to WAC 388-502-0160(6)].

Additional records required specific to MAA's Dental Program:

- Periodontal charting;
- Justification for replacement of dentures;
- Charts of missing teeth for replacement of partials;
- Receipts for laboratory costs or laboratory records and notes; and
- Justification for general anesthesia (including deep sedation).

Medical justification is required for all procedures. Missing documentation in the client's record may result in payment recouped from the provider.

Notifying clients of their rights (advance directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the ADA Claim Form

These instructions are based on the American Dental Association 1999, Version 2000.
See sample claim forms, pages G5-G8.

General Information

- Include any required prior authorization number. Prior authorized claim originals must be completed and returned as the billing document.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- Use either blue or black ink only. **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers on claim form.
- These instructions only address those fields that are required for billing MAA.

Send your claims for payment to:

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Field **Description**

2. **Prior Authorization –** Usually filled in by MAA's Dental Authorization staff.

8. **Patient Name:** Enter the client's first name, middle initial (if any), and last name.

12. **Date of Birth** – Enter the client's birthdate (MMDDYY).

13. **Patient ID #:** Enter the client's **Patient Identification Code (PIC)**. MAA identifies clients by this code, not by their name. This alphanumeric code assigned to each MAA client consists of:

- First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (or fewer if the name is less than five letters).
- Alpha or numeric character (tiebreaker).

17. **Relationship to Subscriber/ Employee**: Check the appropriate box.

19. **Subscriber/Employee ID # SSN #**: Enter the dental plan ID # of the employee/subscriber.

20. **Employer Name:** Enter the name of the subscriber's employer.

21. **Group no(s):** Enter the group number(s) of the subscriber to the third-party insurance coverage.

22. **Subscriber/Employee Name** (if different from patient's): Enter the name of the employee/subscriber.

28. **Date of Birth**: Enter the birthdate of the employee/subscriber.

31. **Is patient covered by another dental plan?** Check the appropriate response.

32. **Policy #:** If client has third party coverage, indicate the policy #.

36. **Plan/Program Name**

42. **Name of Billing Dentist or Dental Entity:** Enter the dentist's name or business as recorded with MAA.

43. **Phone Number:** Enter provider's phone number.

44. **Provider ID #:** Enter the provider number assigned to you by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the ***Provider Number*** area at the top of the page. It is this code by which providers are identified, not by provider name. **Without this number, we may be unable to determine the provider and pay the claim.**

46, 50, 51, 52:
Address: Enter the provider's mailing address.

47. **Dentist License #** - Enter the dentist license number.

49. **Place of Treatment**: Enter one of the following codes to show the place of service at which the service was performed:

Office	**3**	dental office
Hosp.	**1**	inpatient hospital
	2	outpatient hospital
	5	hospital emergency room
ECF	**8**	nursing facility
Other	**4**	client's residence
	6	professional services in an ambulatory surgery center
	9	school-based services

53. **Radiographs or models enclosed?** Check the appropriate box. If you check *yes*, indicate how many X-rays are enclosed.

Note:

- Do not send X-rays when billing for services.
- X-rays are necessary only when prior authorization is being requested.
- Please write "X-rays enclosed" on the mailing envelope and mail to the Quality Utilization Section (see Authorization section for address.)

55. **If prosthesis, is this initial placement?** Enter *yes* or *no*. If *no*, enter reason for replacement, date(s) of extraction(s), and if known, dates of prior placement. If applicable, chart missing teeth for partial(s).

56. **Is treatment result of occupational illness or injury?** Check the appropriate box. If *yes*, describe the illness or injury and list date(s) of occurrence/onset.

57. **Is treatment a result of: auto accident? other accident? neither?** Check appropriate box. If *yes*, please describe and give dates.

59. **Examination and treatment plan: Each service performed** must be listed as a separate, complete one-line entry except for x-rays which are allowed multiple units. **Each extraction or restoration** must be listed as a separate line entry.

If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.

Date Service Performed: Enter the six-digit date of service, indicating month, day, and year (e.g., October 1, 2002 = 100102).

Tooth # or Letter: Enter the appropriate tooth number, letter(s):

- 01 through 32 for permanent teeth
- A through T for primary teeth
- SN for supernumerary teeth

Quadrants (Q) or Arches (A) must be identified in the **tooth number column** using one of the following two-digit codes:

UR = Upper Right Quadrant
UL = Upper Left Quadrant
LR = Lower Right Quadrant
LL = Lower Left Quadrant
UA = Upper Arch
LA = Lower Arch

Surface: Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **four codes** may be listed in this column:

M = Mesial
D = Distal
O = Occlusal
I = Incisal
B = Buccal
F = Facial
L = Lingual

Procedure Code: Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

Qty - If procedure code description indicates multiple surfaces, do not enter multiple units in **Qty** field

Example: D2386 Resin-based composite – two surfaces, posterior-permanent. **Enter 1 unit in Qty field**.

Description of Services: Give a brief written description of the services rendered. When billing for general anesthesia, enter actual beginning and ending times. If you were assisting in surgery, please state *"surgical assist"* here. In the **Qty** field, enter the number of units, if applicable. (***Units*** might mean multiple x-rays using the same procedure code; if two x-rays were taken, enter a 2 in this column. If no number is entered, it is assumed that one unit of service was performed.)

If billing for anesthesia, enter *only* the total # of minutes on the claim.

Fee: Enter **your usual and customary fee** (not MAA's maximum allowable rate) for each service rendered.

Total Fee: Total all charges listed.

Payment by other plan: Enter the amount paid by other insurance for these services. Attach the insurance explanation of benefits (EOB) to the claim.

Patient pays: Enter the balance due after insurance.

60. Identify all missing teeth with "X."

61. Remarks for unusual services:

This field may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

Example of Remark: *"Jane Doe, CRNA administered anesthesia."* If you wish to use a medical record number, enter in the Remarks area.

62. Provider Signature: Enter the performing provider's number if it is different from the one shown in *field 44*. If you are a dentist in group practice, please indicate your **unique identification number and/or name**.

63-66.

Address where treatment was performed: Complete this section if the treatment was performed at a different location than indicated in fields 46, 50, 52, 52.

SAMPLE: CROWNS WITH AUTHORIZATION NUMBER

Dental Claim Form

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT Prior Authorization # 491000000
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): DOE DONN I
9. Address
10. City | 11. State
12. Date of Birth (MM/DD/YYYY): 01 / 01 / 55
13. Patient ID #: DI010155DOE A
14. Sex ☐M ☐F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status ☐Married ☐Single ☐Other
30. Sex ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan ☒No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name / Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: DENTAL CLINIC
43. Phone Number: (206) 555-5555
44. Provider ID #: 5310000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 ANY STREET
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other
50. City: ANYTOWN | 51. State: WA | 52. Zip Code: 98123
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No
If service already commenced: Date appliances placed / Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☒Yes ☐No
If no, reason for replacement: / Date of prior placement:
56. Is treatment result of occupational illness or injury? ☒No ☐Yes
Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither
Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
07 01 02	08			D2751	1		600.00
07 01 02	09			D2751	1		600.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	1200.00
Payment by other plan	
Misc. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
5999999 (Performing Provider #)
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 65. Zip Code

Dental Claim Form

SAMPLE: REPLACEMENT DENTURES

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): DOE, DON I
9. Address
10. City | 11. State
12. Date of Birth (MM/DD/YYYY): 01 / 01 / 55
13. Patient ID #: DT010155DOE A
14. Sex: ☐M ☐F
15. Phone Number: ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan: ☒No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: DENTAL CLINIC
43. Phone Number: (206) 555-5555
44. Provider ID #: 5310000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 ANY STREET
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: 3 ☒Office ☐Hosp. ☐ECF ☐Other
50. City: ANYTOWN | 51. State: WA | 52. Zip Code: 98123
53. Radiographs or models enclosed? ☐Yes, How many? _____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No
If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this Initial placement? ☐Yes ☒No — If no, reason for replacement: DAMAGED BEYOND REPAIR — Date of prior placement: 020195
56. Is treatment result of occupational illness or injury? ☒No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
06 01 02				D5110	1		600.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

Total Fee	600.00
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services
PREVIOUS DENTURES DAMAGED BEYOND REPAIR;
HAS BEEN ABLE TO WEAR SUCCESSFULLY IN PAST

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. 5999999 (PERFORMING PROVIDER #)
X _____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

Dental Claim Form

SAMPLE: REQUEST FOR APPROVAL

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): DOE JOHN I
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY): 01 / 01 / 28
13. Patient ID #: J1010128DOE A
14. Sex: ☐M ☐F
15. Phone Number: ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

30. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan: X No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: DENTAL CLINIC
43. Phone Number: 206) 555-5555
44. Provider ID #: 5310000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 ANY STREET
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other
50. City: ANYTOWN
51. State: WA
52. Zip Code: 98123
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☐No
If service already commenced:
Date appliances placed
Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement:
Date of prior placement:
56. Is treatment result of occupational illness or injury? ☒No ☐Yes
Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither
Brief description and dates

58. Diagnosis Code Index (optional)
1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Teeth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
				0515D	1	UPPER DENTURES/ PATIENT DIED	200.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	200.00
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services
REQUEST FOR AUTHORIZATION - PATIENT DIED BEFORE DENTURE SEATING.

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X 5999999 (Performing Provider #)
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

Dental Claim Form

SAMPLE: ORTHODONTIC CLAIM W/AUTHORIZATION

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #: 481000000
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): DOE DEBBIE A
9. Address
10. City | 11. State
12. Date of Birth (MM/DD/YYYY): 01 '01 '86
13. Patient ID #: DA010186DOE A
14. Sex: ☐M ☐F
15. Phone Number: ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number: ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY): / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan: ☒No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY): / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name / Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: DENTAL CLINIC
43. Phone Number: (206) 555-5555
44. Provider ID #: 5310000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 123 ANY STREET
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: 3 ☒Office ☐Hosp. ☐ECF ☐Other
50. City: ANYTOWN | 51. State: WA | 52. Zip Code: 98123
53. Radiographs or models enclosed? ☐Yes, How many? ____ ☐No
54. Is treatment for orthodontics? ☒Yes ☐No — If service already commenced: Date appliances placed: 040102 — Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☒No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☒neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
0301	02			0807D	1		200.00
0401	02			0872D	1		1200.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

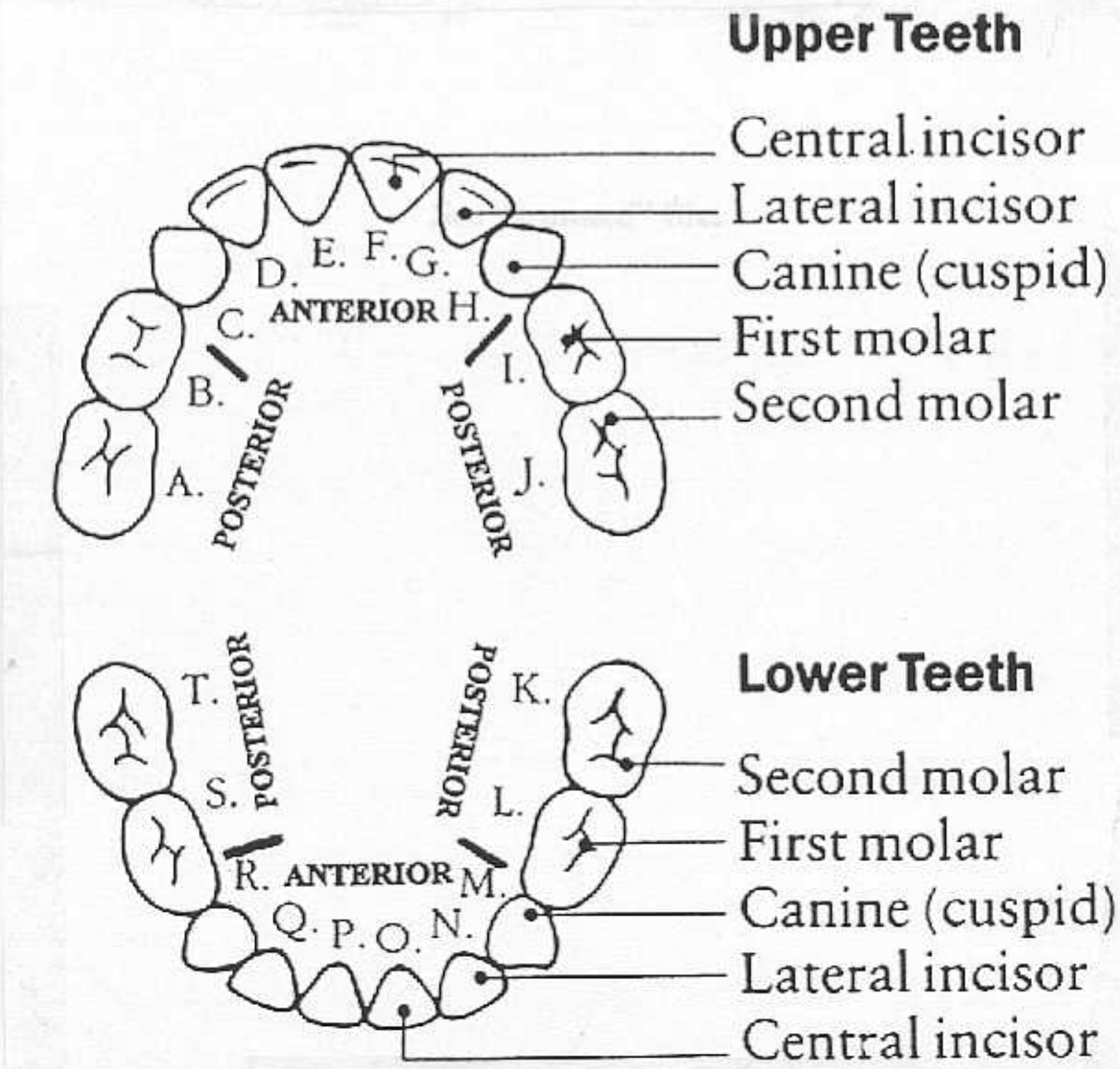
Total Fee	1400.00
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

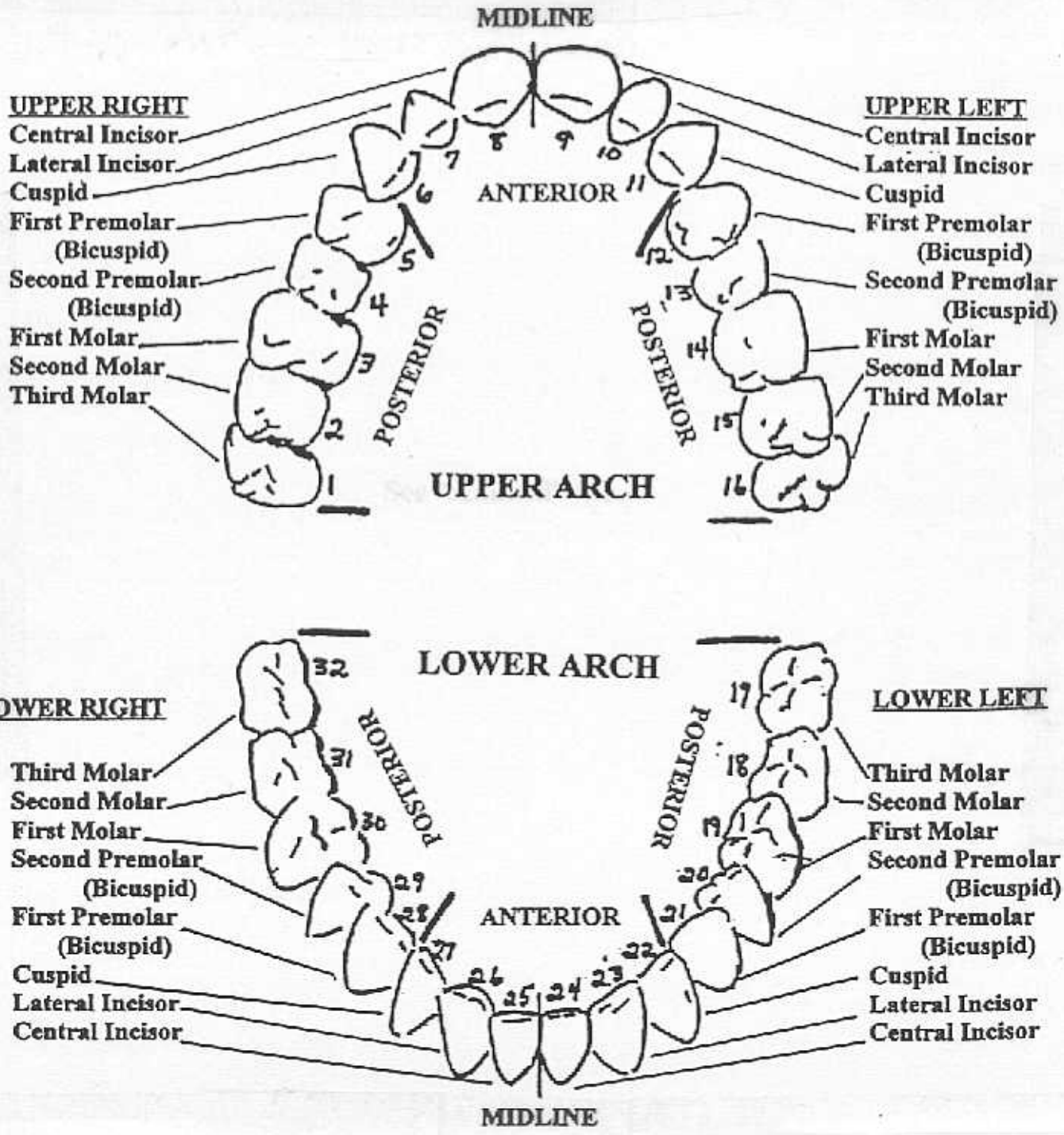
62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. 5999999 (Performing Provider #)
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

Primary Teeth
Name and Letter



Permanent Teeth
Names and Numbers



Dental Fee Schedule

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT, State-Unique, or CPT™)
Column 2: Description/Limitations
Column 3: Prior Auth? Is prior authorization required?
Column 4: Maximum Allowable – Children 18 years of age or younger.
Column 5: Maximum Allowable – Adults 19 years of age or older.

– OR –

Column 3: Oral Surgery Follow-up Days
Column 4: Assistant Surgeon Allowed?
Column 5: Nonfacility Setting (NFS) Maximum Allowable – Clients all ages.
Column 6: Facility Setting (FS) Maximum Allowable – Clients all ages.

- Always bill your usual and customary fee(s) (not MAA's maximum allowable amount).
- For certain procedures, there are separate reimbursement rates for children (0 through 18 years of age) and adults (19 years of age or older). These are indicated in the maximum allowable column in the fee schedule.

Remember: You may bill only after services have been provided, but we must receive your bill within 365 days from the date of service.

Site of Service (SOS) Payment Differential

Note: SOS pertains only to CPT™ oral surgery and orthodontic Evaluation and Management (E&M) codes.

How are fees established for the professional services performed in the facility and non-facility settings?

Based on the Resource-Based Relative Value Scale (RBRVS) methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components (work, practice expense and malpractice expense). MAA uses the two levels of practice expense to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS MAF) –** Paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS MAF) –** Paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and Management codes, which specify the site of service within the description of the procedure codes; and
- Major surgical procedures that are generally only performed in hospital settings.

How will the site of service payment policy affect provider reimbursements?

Providers billing professional services will be reimbursed at one of two maximum allowable fees, depending on where the service is performed.

Does MAA reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments, one to the performing provider and another to the facility. The reimbursement to the facility includes the payment for resources. The NFS MAF includes the allowance for resources.

The professional FS MAF excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower of FS MAF to performing providers when the facility is also reimbursed eliminates duplicate payment for resources.

When are professional services reimbursed at the Facility Setting Maximum Allowable Fee?

Providers are reimbursed at the FS MAF when MAA also makes a payment to a facility. MAA will follow the Centers for Medicare and Medicaid Services' (CMS) determination for using the FS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the FS MAF:

MAA Place of Service Code	CMS Place of Service Description
1	Inpatient Hospitals
1	Inpatient Psychiatric Facility
1	Comprehensive Inpatient Rehabilitation Facility
2	Outpatient Hospital
2	Hospice
2	Psychiatric Facility Partial Hospitalization
2	Comprehensive Outpatient Rehabilitation Facility
2	End-Stage Renal Disease Treatment Facility
5	Emergency Room – Hospital
6	Ambulatory Surgery Center
7	Intermediate Care Facility/Mentally Retarded
8	Skilled Nursing Facility
8	Nursing Facility

When are professional services reimbursed at the Non-Facility Setting Maximum Allowable Fees?

The NFS MAF is paid when MAA does not make a separate payment to a facility. Services performed in a provider's office, client's home, facility or institution (listed in the following table) will be reimbursed at the NFS MAF. MAA will follow CMS's determination for using the NFS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the NFS MAF:

MAA Place of Service Code	CMS Place of Service Description
3	Office*
3	Federally Qualified Health Center
3	Community Mental Health Center
3	State or Local Public Health Clinic
3	Rural Health Clinic
3	Independent Laboratory
4	Client's Private Residence
9	Birthing Center
9	Military Treatment Facility
9	Custodial Care Facility
9	Adult Family Homes
9	Boarding Homes (e.g., Assisted Living Facility, Enhanced Adult Residential Care Facility, Adult Residential Care Facility)
9	Psychiatric Residential Treatment Center
9	Other Unlisted Facility

* Includes Neurodevelopmental Centers

Diagnostic

Clinical Oral Evaluations

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up
D0120	**Periodic oral evaluation** A periodic evaluation is allowed once every six months. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation.	No	$22.00	$22.00
D0140	**Limited oral evaluation** An evaluation limited to a specific oral health problem. It may not be billed when any prescheduled dental service is provided on the same date- except for palliative treatment, x-rays, and tests necessary to diagnose the emergency condition. A limited exam may be billed when providing an evaluation for a referral.	No	$20.00	$20.00
D0150	**Comprehensive oral evaluation** For MAA purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or clinic. Normally used by a general dentist and/or a specialist when evaluating a patient comprehensively. Includes evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, etc. *Six months must elapse before a periodic evaluation will be reimbursed.*	No	$34.00	$27.00

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Limited visual oral assessment

Bill for children ages 0 through 18 and adult DDD clients only.

Use this code when:

- ✓ Assessing the need for sealants to be placed by a dental hygienist;
- ✓ Screening children in Head Start or ECEAP programs;
- ✓ Providing triage services; or
- ✓ In circumstances where the child will be referred to another dentist for treatment (the referring dentist will not provide treatment nor provide a full evaluation at the time of the assessment).

This code should also be used by public health dental hygienists performing an intraoral screening of soft and hard tissues to assess the need for prophylaxis, sealants, fluoride varnish, or referral for other dental treatments by a dentist. It also includes appropriate referrals, charting patient data and oral health status, and informing the parent or guardian of the results.

A limited visual oral health assessment does not replace an oral evaluation by a dentist.

4420D	**Limited visual oral assessment, low risk** Client has no visible dental caries requiring referral for restorative dental intervention.	No	$10.00	$10.00 **DDD clients only**
4421D	**Limited visual oral assessment, moderate risk** Client has visible dental caries requiring referral for restorative dental intervention.	No	$10.00	$10.00 **DDD clients only**
4422D	**Limited visual oral assessment, high risk** Client has urgent dental disease with visible infection related to caries, with or without pain; requires immediate referral for dental intervention.	No	$10.00	$10.00 **DDD clients only**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Radiographs

D0210	**Intraoral – complete series** (including bitewings) Complete series x-rays will be allowed only once in a 3-year period. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.	No	$45.00	$35.00
D0220	**Intraoral periapical – single, first film**	No	$8.00	$7.00
D0230	**Intraoral periapical – each additional film**	No	$2.40	$1.50
D0240	**Intraoral – occlusal, film**	No	$9.00	$7.00
When billing D0270 and D0272 on the same date of service, MAA's payment is the same as for D0274.				
D0270	**Bitewing – single film** Total of 4 bitewings allowed every 12 months.	No	$8.00	$6.00
D0272	**Bitewings – 2 films** Total of 4 bitewings allowed every 12 months	No	$10.40	$7.00
D0274	**Bitewings – 4 films** Total of 4 bitewings allowed every 12 months.	No	$12.80	$9.00
D0321	**Temporomandibular joint film**	No	$50.50	$36.78
D0330	**Panoramic film – maxilla and mandible** Allowable for oral surgical and orthodontic purposes only. Not to be used for restoration diagnostic purposes. Documentation must be entered in the client's file. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 3-year period. A shorter interval between panoramic–type x-rays may be allowed for: • Emergent services, with authorization from MAA within 72 hours of the service; • Oral surgical and orthodontic services, with written prior authorization from MAA; or • Preoperative or postoperative surgery cases. Preoperative xrays must be provided within 14 days prior to surgery, and postoperative x-rays must be provided within 30 days after surgery. **Doing <u>both</u> a panoramic film and an intraoral complete series is not allowed.**	No	$43.00	$27.00

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Test and Laboratory Examination

D0460	**Pulp vitality test** • Allowed one time per day (not per tooth); • For diagnosis of emergency conditions only; and • Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.	No	$1.00	$1.00
D0501	**Histopathologic examination** Histological examination of oral hard/soft tissue.	No	$42.42	$40.98

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Preventive

Prophylaxis (Scaling and coronal polishing)

- No additional allowance will be given for a cavitron or ultrasonic scaling.
- Prophylaxis and topical application of fluoride must be billed separately.
- Not allowed when performed on the same date of service as periodontal scaling or gingivectomy.

D1110	**Prophylaxis, adult age 19 and up** Allowed once every twelve months. A treatment performed on permanent dentition that includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	No	Not Covered	$37.00
D1120	**Prophylaxis, child age 8-18** Allowed once every six months. Scaling and polishing performed to remove coronal plaque, calculus and stains. For state purposes, this code applies to primary, transitional, and permanent dentition.	No	$23.23 **(8-18 years only)**	**Use Code Above**
0113D	**Prophylaxis for developmentally disabled (DDD) clients only.** Allowed 3 times, per calendar year.	No	$40.00	$40.00
D1330	**Oral hygiene instructions** Allowed once per calendar year for children 0 through 7 years of age. Examples include instructions for home care, tooth brushing technique, flossing, use of special oral hygiene aids. For the purposes of this program, rubber cup and bristle prophylaxis are covered under this code as a component of oral health instruction.	No	$15.15 **(0-7 years only)**	**Not Covered**
4112D	**Second oral hygiene instructions** Allowed once per calendar year for children 0 through 7 years of age. Examples include instructions for home care, tooth brushing technique, flossing, use of special oral hygiene aids. For the purposes of this program, rubber cup and bristle prophylaxis are covered under this code as a component of oral health instruction.	No	$5.05 **(0-7 years only)**	**Not Covered**

Fluoride Treatments

- Fluoride treatments are not covered as a routine adult service for persons 19-64 years of age. This service requires prior authorization for this age group, unless provided to a DDD client.
- Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up
D1203	**Topical application of fluoride [gel or varnish] – one treatment** (excluding prophylaxis). Allowed up to three times in a 12-month period. Additional applications may be reimbursed with prior authorization.	No	$13.39	$13.39 **DDD clients**
	For high-risk adults age 65 and older, topical application of fluoride gel or varnish for only: • Rampant root surface decay; or • Xerostomia (reduced salivary flow).	No		$13.39 **High-risk adults Age 65 and older**
	For adults age 19 through 64, topical application of fluoride gel or varnish for xerostomia only.	**Yes**		$13.39 **High-risk adults 19-64 years old**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Other Preventive Services

- Sealants may be applied to occlusal surfaces of primary and permanent maxillary and mandibular first and second molars and lingual pits of teeth 7 and 10.
- Only teeth with no decay will be covered.
- Sealants are restricted to children 0 through 18 years of age.
- The application of pit and fissure sealants will be covered only once per tooth in a 3-year period.

D1351	**Topical application of sealants – per tooth** Tooth and surface designations required. Includes glass ionomer sealants.	No	$22.22	**Not Covered**

Space Maintenance

Space maintainers will be allowed as follows:

- To hold space for missing first and/or second primary molars. Space maintainers are allowed for maintaining positioning for permanent teeth for spaces A, B, I, J, K, L, S and T for clients 18 years of age and under.
- No additional allowance will be given on a lingual arch space maintainer for 3 teeth.
- No reimbursement will be allowed for removing retainers.
- Vertical space maintainers are not covered.

D1510	**Space maintainer - fixed – unilateral** Allowed only once per quadrant. Quadrant designation required.	No	$80.80	**Not Covered**
D1515	**Space maintainer – fixed – bilateral** Allowed only once per arch. Arch designation required.	No	$121.20	**Not Covered**
D1550	**Recementation of space maintainer** Allowed once per quadrant or arch. Quadrant or arch designation required.	No	$28.28	**Not Covered**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Restorative

- Multiple restorations involving the same surface of the same tooth are considered as a single surface and are reimbursed as such.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration and are reimbursed as such.
- Reimbursement for all pit restorations is allowed as though for one surface amalgam.
- Bases and polishing amalgams are included in the allowance for the major restoration.
- Amalgams and resin-based composite restorations are covered only once in a 2-year period. This applies only to the same surface of the same tooth. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a 2-year period requires written justification on claim form and in patient record.
- Amalgam and/or resin build-ups are included in reimbursement for crowns.
- MAA does not cover flowable composites as a restoration.

Amalgam Restorations (including polishing)

D2110	**Amalgam – 1 surface, primary** Tooth and surface designations required.	No	$50.50	$24.17
D2120	**Amalgam – 2 surface, primary** Tooth and surface designations required.	No	$62.62	$34.68
D2130	**Amalgam – 3 (or more) surfaces, primary** Tooth and surface designations required. It is anticipated that a crown would be considered rather than 4 amalgam restorations on a primary tooth.	No	$70.70	$39.93
D2140	**Amalgam – 1 surface, permanent** Tooth and surface designations required.	No	$50.50	$36.06
D2150	**Amalgam – 2 surfaces, permanent** Tooth and surface designations required**.**	No	$62.62	$48.42
D2160	**Amalgam – 3 surfaces, permanent** Tooth and surface designations required.	No	$70.70	$59.75
D2161	**Amalgam – 4 or more surfaces, permanent** Tooth and surface designations required.	No	$70.70	$70.40

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Resin-Based Composite Restorations

(Composite/Glass Ionomer)

Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a one or two-surface restoration.				
D2330	**Resin-based composite – 1 surface, anterior** Tooth and surface designations required.	No	$60.00	$34.68
D2331	**Resin-based composite – 2 surfaces, anterior** Tooth and surface designations required.	No	$65.65	$52.54
D2332	**Resin-based composite – 3 surfaces, anterior** Tooth and surface designations required.	No	$70.70	$67.25
D2335	**Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)** Tooth and surface designations required.	No	$70.70	$79.87
D2336	**Resin-based composite crown, anterior-primary.** Tooth designation required.	No	$95.00	$53.59
D2380	**Resin-based composite – 1 surface, posterior – primary** Tooth and surface designations required.	No	$50.50	$24.17
D2381	**Resin-based composite – 2 surface, posterior-primary** Tooth and surface designations required.	No	$62.62	$34.68
D2382	**Resin-based composite – 3 or more surfaces, posterior-primary** Tooth and surface designations required.	No	$70.70	$39.93
D2385	**Resin-based composite – 1 surface, posterior-permanent** Tooth and surface designations required.	No	$50.50	$36.06
D2386	**Resin-based composite – 2 surfaces, posterior-permanent** Tooth and surface designations required.	No	$62.62	$48.42
D2387	**Resin-based composite – 3 surfaces, posterior-permanent** Tooth and surface designations required.	No	$70.70	$70.00
D2388	**Resin-based composite, 4 or more surfaces, posterior-permanent**	No	70.70	70.00

Crowns

Use the final seating date, not the preparation date, as the date of service.

Criteria for crowns

[Refer to WAC 388-535-1230]

- Crowns may be authorized when the crown is medically necessary.
- Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if the tooth is crowned.

  The provider must submit the following information:

  - ✓ The overall condition of the mouth;
  - ✓ Oral health status;
  - ✓ Assessment of client's maintenance of good oral health;
  - ✓ Arch integrity; and
  - ✓ Prognosis of remaining teeth.

- Anterior teeth must show traumatic or pathological destruction or loss of at least one incisal angle.

> Note: The fee for crowns includes tooth and soft tissue preparation and seating, amalgam build-ups or resin-based composites, temporary restoration, cement base, insulating bases, impressions, and local anesthesia.

Crowns not requiring prior authorization

[WAC 388-535-1230]

MAA covers the following crowns without prior authorization:

- Stainless steel – MAA considers these as permanent crowns, and does not cover them as temporary crowns; and
- Non-laboratory resin for primary anterior teeth.

Crowns that require prior authorization

Laboratory Processed Crowns

[Refer to WAC 388-535-1230(3)(5)]

- MAA requires prior authorization for the following crowns, which are limited to single restorations for permanent anterior teeth (upper – 6-11 and lower – 22-27);

  a) Resin (laboratory);
  b) Porcelain with ceramic substrate;
  c) Porcelain fused to high noble metal;
  d) Porcelain fused to predominately base metal; and
  e) Porcelain fused to noble metal.

- MAA covers the laboratory processed crowns listed above:

  ✓ Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronal restoration;

  ✓ Only once per permanent tooth in a five-year period;

  ✓ For endodontically-treated anterior teeth only after satisfactory completion of the root canal therapy. Post-endodontic treatment X-rays must be submitted for prior authorization of these crowns.

  Note: Endodontic treatment is not sole justification for authorization of a crown.

- MAA does not cover laboratory-processed crowns for posterior teeth.

Radiographs are required by MAA for confirmation that the requested service meets criteria.

Reimbursement for crowns

[Refer to WAC 388-535-1230(6)]

MAA reimburses only for the covered crowns listed in this section. The reimbursement is full payment; all of the following are included in the reimbursement and must not be billed separately:

- Tooth and soft tissue preparation;
- Resin-based composites or amalgam build-ups;
- Temporary restoration;
- Cement bases;
- Insulating bases;
- Impressions;
- Seating; and
- Local anesthesia.

Temporary crowns are included in MAA's total reimbursement for crowns. MAA does not reimburse separately for temporary crowns.

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up
Prior authorization is required for all but one of the following crowns. Payment will be denied for claims without prior authorization. Temporary crowns are included in MAA's total reimbursement for crowns. MAA does not reimburse separately for temporary crowns.				
D2336	**Resin-based composite crown - anterior-primary** Tooth designation required.	No	$95.00	$53.59
D2710	**Crown – resin (laboratory)** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	$150.00	$150.00
D2740	**Crown – porcelain/ceramic substrate** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	$350.00	$309.06
D2750	**Crown – porcelain fused to high noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	$350.00	$309.06
D2751	**Crown – porcelain fused to predominantly base metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	$350.00	$309.06
D2752	**Crown – porcelain fused to noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	$350.00	$309.06

Other Restorative Services

D2910	**Recement inlay** Tooth designation required.	No	$17.17	$16.81
D2920	**Recement crown** Tooth designation required.	No	$20.20	$16.81
D2930	**Prefabricated stainless steel crown – primary tooth** Tooth designation required.	No	$90.00	$53.59
D2931	**Prefabricated stainless steel crown – permanent tooth** Tooth designation required.	No	$90.00	$80.00
D2933	**Prefabricated stainless steel crown with resin window** Covered for upper anterior primary teeth C through H only. Tooth designation required.	No	$105.00	**Not Covered**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Endodontic

Pulpotomy (excluding final restoration)

D3220	**Therapeutic pulpotomy** Covered only as complete procedure, once per tooth. **For primary teeth only.** Tooth designation required.	No	$44.44	$35.73

Root Canal Therapy

- Includes clinical procedures and follow-up care.
- Separate charges are allowable for open and drain and for root canal treatments if the procedures are done on different days.
- **Not covered for primary teeth.**

D3310	**Anterior (excluding final restoration)** Tooth designation required.	No	$250.00	$165.00
D3320	**Bicuspid (excluding final restoration)** Tooth designation required.	No	$270.00	$200.00
D3330	**Molar (excludes final restoration)** Tooth designation required. Not covered for wisdom teeth.	No	$290.00	$220.00

Apexification/Recalcification Procedures

- **Not covered on primary teeth.**

D3351	**Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.) Tooth designation required.	No	$70.70	$41.21
D3352	**Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits. MAA pays up to five (5) medically necessary visits. Tooth designation required.	No	$35.35	$26.28

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Apexification/Periradicular Services

- **Not covered on primary teeth**

D3410	**Apicoectomy/periradicular surgery – anterior** For surgery on root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.	No	$156.55	$136.61
D3421	**Apicoectomy/periradicular surgery – bicuspid (first root)** For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see D3426. Tooth designation required.	No	$156.55	$136.61
D3425	**Apicoectomy/periradicular surgery – molar (first root)** For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426. Tooth designation required.	No	$156.55	$136.61
D3426	**Apicoectomy/periradicular surgery (each additional root)** Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include placement of retrograde filling material. Tooth designation required.	No	$47.47	$46.24
D3430	**Retrograde filling, per root** Only covered if done with apicoectomy. Tooth designation required.	No	$46.46	$27.33

Other Endodontic Procedures

- **Anterior primary teeth are not covered**

D3950	**Canal preparation and fitting of preformed dowel or post.** MAA covers only the dowel or post portion of this procedure. Payable only once per tooth and may include multiple dowels or posts. Tooth designation required.	No	$25.25	$22.07

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Periodontics

Surgical Services

D4210	**Gingivectomy - per quadrant** (Gingivoplasty is not covered by MAA – even though it is part of the ADA description.) Gingivectomy, quadrant designation required.	No	$101.00	$52.54

- Periodontal scaling and root planing is allowed when the patient has radiographic evidence of periodontal disease, with at least 4mm pocketing.
- Ultrasonic scaling/gross scaling does not qualify for a separate fee; it is included in other periodontal procedures.
- Root planing is covered once per quadrant in a 24-month period.
- **Not covered for clients 0-18 years of age unless DDD client.**
  Root planing is covered every 6 months for DDD clients.
- Quadrant designation required. Adequate supporting documentation including complete periodontal charting and a definitive periodontal diagnosis must be available to MAA.
- Not allowed when performed on the same date of service as adult prophylaxis, or gingivectomy.

D4341	**Periodontal scaling and root planing, per quadrant**	No	$25.76 **DDD clients only**	$26.28
0435D	**Periodontal scaling and root planing (1-4 teeth, per quadrant)**	No	$13.39 **DDD clients only**	$13.66

Dentures/Partials

Use the seating date to bill for dentures.

Initial Set of Dentures

[Refer to WAC 388-535-1240(1)(2)]

- MAA covers only one set of dentures per client in a 10-year period and considers that set to be the first set. (The exception to this is replacement dentures, which may be allowed as specified under *Replacement of Complete or Partial Dentures*.)

- **MAA does not require prior authorization for the first set of dentures.** (See exception for laboratory and professional fees for dentures and partials, page H22)

- The first set of dentures may be any of the following:

  a. An immediate set (constructed prior to removal of teeth); or
  b. An initial set (constructed after the client has been without teeth for a period of time).

- The first set of dentures must be of the structure and quality to be considered the primary set.

- MAA does not cover transitional or treatment dentures.

Partials

[Refer to WAC 388-535-1240(3)]

- MAA covers partials (resin and cast base) once every 5 years subject to the following limits. (The exception to this is replacement dentures, which may be allowed as specified under *Replacement of Complete or Partial Dentures*.):

  a. Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and
  b. No partials are covered when they replace wisdom teeth only.

Replacement of Complete or Partial Dentures

[Refer to WAC 388-535-1240(4)]

- Prior authorization for replacement of complete or partial dentures is not required when:

  a. The client's existing dentures or partials meet any of the following conditions. The dentures or partials must be:

     i. No longer serviceable and cannot be relined or rebased; or
     ii. Damaged beyond repair.

  MAA requires prior authorization for replacement dentures or partials requested within one year of the seat date.

  b. The client's health would be adversely affected by absence of dentures;
  c. The client has been able to wear dentures successfully;
  d. The dentures or partials meet the criteria of medically necessary; and
  e. The dentures are replacing lost dentures, and the replacement set does not exceed MAA's limit of one set in a 10-year period.

- The provider must document in the client's medical or dental record:

  a. Justification for replacement of dentures;
  b. Charts of missing teeth, for replacement of partials; and
  c. Receipts for laboratory costs or laboratory records and notes.

For partial dentures:

- ✓ Chart the **missing teeth** on the claim form **and** in the client's record; **and**
- ✓ In the "Remarks for Unusual Services" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
- ✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

Laboratory and Professional Fees for Dentures and Partials

[Refer to WAC 388-535-1240(5)]

- MAA does not reimburse separately for laboratory and professional fees for dentures and partials. However, MAA may partially reimburse for these when the provider obtains authorization because the client:

  a. Dies;
  b. Moves from the state;
  c. Cannot be located; or
  d. Does not participate in completing the dentures.

Rebase [Refer to WAC 388-535-1240(10)]

MAA covers one rebase in a five-year period. The dentures must be at least three years old.

Billing

[Refer to WAC 388-535-1240(7)(8)(9)]

- For billing purposes, the provider must use the delivery date. The impression date may be used for dentures, including partials, only when:

  a. Related dental services including laboratory services were provided during a client's eligible period; and
  b. The client is not eligible at the time of delivery.

- For billing purposes, the provider must use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.

- MAA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with RCW 18-32.695.

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Complete Dentures (including 6 months post-delivery care)

- The MAA dental program covers one set of dentures in a 10-year period.
- Dentures placed immediately must be of structure and quality to be considered the permanent set. *Transitional* or *treatment* dentures are *not* covered.
- No additional reimbursement is allowed for *denture insertions.*

D5110	**Complete denture – maxillary** (upper)	No	$398.00	$398.00
D5120	**Complete lower – mandibular** (lower)	No	$398.00	$398.00
D5130	**Immediate denture – maxillary** (upper) Appropriate radiographs must be submitted to MAA.	No	$398.00	$398.00
D5140	**Immediate denture – mandibular** (lower) Appropriate radiographs must be submitted to MAA.	No	$398.00	$398.00

Partial Dentures (including 6 months post-delivery care)

- One partial per arch is covered.
- D5211 and D5212 are covered for 1 or more teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing 3 or more teeth per arch, excluding wisdom teeth.
- MAA pays for partials covered by MAA once in 5 years.

D5211	**Maxillary partial denture – resin base (includes any conventional clasps, rests and teeth)**	No	$240.00	$240.00
D5212	**Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)**	No	$240.00	$240.00
D5213	**Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	No	$348.00	$348.00
D5214	**Mandibular partial denture – cast metal framework with resin denture bases (includes any conventional clasps, rests and teeth)**	No	$348.00	$348.00

Complete/Partial Dentures

0515D	**Dentures/partials where patient died, moved, etc.** Laboratory and professional fees may be paid for full or partial dentures if the patient • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. Invoice must be attached listing lab and professional fees.	Yes	**By Report**	**By Report**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Adjustments to Dentures and Partials

- No allowance for adjustments for 6 months following placement.
- Adjustments done during this period are included in denture/partial allowance.

D5410	**Adjust complete denture – maxillary** (upper)	No	$16.48	$15.76
D5411	**Adjust complete denture – mandibular** (lower)	No	$16.48	$15.76
D5421	**Adjust partial denture – maxillary** (upper)	No	$16.48	$15.76
D5422	**Adjust partial denture – mandibular** (lower)	No	$16.48	$15.76

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	$37.09	$34.68
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	$32.97	$31.53
0552D	**Each additional tooth** Tooth designation required.	No	$9.27	$8.40

Repairs to Partial Dentures

D5610	**Repair resin denture base** Arch designation required.	No	$34.00	$32.58
D5630	**Repair or replace broken clasp** Arch designation required.	No	$51.51	$48.34
D5640	**Replace broken teeth – per tooth** Use for initial tooth. Tooth designation required.	No	$32.97	$31.53
0565D	**Each additional tooth** Tooth designation required.	No	$9.27	$8.40
D5650	**Add tooth to existing partial denture** To replace extracted tooth; each tooth. Does not involve clasp or abutment tooth. Tooth designation required.	No	$39.15	$36.78
D5660	**Add clasp to existing partial denture** To replace extracted tooth; each tooth. Involves clasp or abutment tooth. Tooth designation required.	No	$87.57	$83.02

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Denture Rebase Procedures

D5710	**Rebase complete maxillary denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	$190.59	$180.74
D5711	**Rebase complete mandibular denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	$190.59	$180.74
D5720	**Rebase maxillary partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	$123.62	$116.64
D5721	**Rebase mandibular partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	$123.62	$116.64

Denture Relining

- Relines are included in allowance for dentures if service is provided within first six months of placement of dentures.
- Reline of partial or full dentures is not allowed more than once in a 5-year period.

D5750	**Reline complete maxillary denture (laboratory)**	No	$111.26	$105.08
D5751	**Reline complete mandibular denture (laboratory)**	No	$111.26	$105.08
D5760	**Reline maxillary partial denture (laboratory)**	No	$101.99	$96.68
D5761	**Reline mandibular partial denture (laboratory)**	No	$101.99	$96.68

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Other Removable Prosthetic Services

D5850	**Tissue conditioning, maxillary** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	$19.57	$18.91
D5851	**Tissue conditioning, mandibular** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	$19.57	$18.91
D5860	**Overdenture – Complete** Arch designation required.	No	$	$
D5932	**Obturator prosthesis, definitive**	No	$544.98	$515.95
D5933	**Obturator prosthesis, modification**	No	$120.00	**Not Covered**
D5952	**Speech aid prosthesis, pediatric** Covered for clients 19 and 20 years old for cleft palate.	No	$762.35	$721.91

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Prosthodontics, Fixed Repairs

0663D	**Replace, repair, or fabricate broken facing** Tooth designation required.	No	$70.05	$66.20
D6930	**Recement fixed partial denture (bridge)**	No	$34.00	$32.58

Management of Temporomandibular Joint Dysfunction

D7880	**Occlusal orthotic device** Laboratory-processed only. Requires prior authorization. Justification must include diagnosis. Laboratory invoice must be kept in the client's file. The maximum allowance includes all professional fees, lab costs, and all required follow-ups. One appliance allowed in a two-year period. **Use the seat date to bill for occlusal orthotic device.**	**Yes**	**By Report**	**By Report**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	19 yrs & up

Oral Surgery – Dentists

Includes Preoperative and Postoperative Treatment
MAA covers medically necessary services provided to eligible clients in a hospital setting for the care or treatment of teeth, jaws, or structures directly supporting the teeth:
(a) If the procedure requires hospitalization; and
(b) A physician or dentist provides or directly supervises such services.
[WAC 388-550-1100(6)]
MAA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7110	**Single tooth** (initial) Tooth designation required.	No	$78.46	$45.00
D7120	**Each additional tooth** (same day) Tooth designation required.	No	$24.24	$25.22
D7130	**Root removal – exposed roots** Example: Patient with missing crown. Tooth designation required.	No	$37.37	$30.48

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Anterior teeth (7-10 and 23-26) require prior authorization and must be radiographically justified. Tooth designation required.	**See Desc.**	$90.00	$65.00
D7220	**Removal of impacted tooth – soft tissue** Tooth designation required.	No	$90.90	$76.71
D7230	**Removal of impacted tooth – partially bony** Tooth designation required.	No	$130.00	$120.00
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation required.	No	$150.00	$140.00
D7241	**Removal of impacted tooth - completely bony, with unusual surgical complications** Allowed only when pathology is present. Tooth designation required.	No	$200.00	$180.00

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up
D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation required.	No	$80.80	$48.34

Other Surgical Procedures

D7270	**Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus** Permanent teeth only. Tooth designation required.	No	$106.05	$78.82
D7280	**Surgical exposure of impacted or unerupted tooth for orthodontic reasons.** Includes orthodontic attachments. Tooth designation required; limited to clients 18 years of age and under.	No	$154.53	**Not Covered**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Adjunctive General Services

Unclassified Treatment

D9110	**Palliative (emergency) treatment of dental pain – minor procedure** Emergency palliative treatment is: • Allowed only when no other definitive treatment is performed on the same day; and • Allowed once per client, per day. Separate charges are allowable for open and drain and for root canal treatment if the procedures are performed on different days. A description of the service must be documented in the client's file.	No	$45.00	$45.00

Anesthesia

- To bill conscious sedation with parenteral or multiple oral agents, the provider must have a current Conscious Sedation Permit from the Department of Health (DOH) or National Health Corps (NHC) on file with MAA.
- To bill general anesthesia (including deep sedation), the provider must have a current General Anesthesia Permit from DOH on file with MAA.
- Copies of permits must be on file with the Provider Enrollment Unit prior to administering the service. See "Important Contacts" for address.
- The provider must meet at least the requirements addressed in DOH WAC 246-817-760 (Conscious sedation with parenteral or multiple oral agents) and WAC 246-817-770 (General Anesthesia); or the prevailing standard of care.
- MAA pays for general anesthesia (including deep sedation) administered by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). Anesthesiologists and CRNAs may bill using the MAA's Physician-Related Services Billing Instructions. See Important Contacts for information on how to obtain a copy.

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

- When billing for general anesthesia, show the actual beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- When general anesthesia (to include deep sedation) is administered by:

  - ✓ The attending dentist, payment will be made at the rate of 50% of the maximum allowable.
  - ✓ A provider other than the attending dentist, maximum allowance is paid.

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 61) of the claim form, if that provider is different from the billing provider.

- MAA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

  $78.50 + [TIME UNITS X $15.70] = MAXIMUM ALLOWABLE FEE
  Note: Every 15 minute increment or fraction equals 1 time unit.

- Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see Important Contacts).

D9220	**General anesthesia (including deep sedation)** Requires documented justification (e.g., client mentally impaired, difficult surgery, fractures for children). **(A General Anesthesia permit is required to be on file with MAA from the provider/performing provider.)**	No	**By Report**	**By Report**
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide**	No	$6.18	$6.18 **DDD clients only**
D9241	**Intravenous sedation/analgesia** (Conscious sedation with parenteral or multiple oral agents) **(A Conscious Sedation permit or General Anesthesia permit is required to be on file with MAA from the provider/performing provider.)**	**No**	$50.00	$50.00

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings, or for multiple facilities.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.
- Mass screening for dental services of clients residing in a facility is not permitted.

D9410	**Bedside call, nursing facility or residence, at the request of the physician.** Allowed once per day, per provider, regardless of the number of clients seen.	No	$32.32	$31.53
D9420	**Hospital calls (includes emergency care)** Allowed once per day, per client. Not covered for routine preoperative and postoperative visits.	No	$32.32	$31.53

Drugs

D9610	**Therapeutic drug injection.** Antibiotics only. Includes cost of drug.	No	$20.00	$20.00
D9630	**Other drugs and/or medicaments** Bill pharmaceuticals using this procedure code. Payable only when billed with either D9220 or D9241. MAA limits this procedure code to IV medicaments and multiple conscious sedation agents only.	No	**By Report**	**By Report**

Procedure Code	Description	Prior Auth?	Maximum Allowable 0-18 yrs	Maximum Allowable 19 yrs & up

Miscellaneous Services

D9920	**Behavior management** Involves a patient whose documented behavior requires the assistance of **more than one additional dental professional staff** to protect the patient from self-injury while treatment is rendered.	No	$27.00	$27.00 **DDD clients only**
D9951	**Occlusal adjustment, limited** • Allowed once every 12 months – per quadrant; • Quadrant designation required; and • Is included in the fee for restorations or crowns placed by the same provider.	No	$14.14 **13-18 yrs only**	$13.66

Note: **See CDT code D9230 for Nitrous Oxide.**
Not included under Behavior Management.

Oral Surgery

Hospital

1. Short Stay/Outpatient

- Medically necessary dental-related hospital short stays do not require authorization. Documentation must be maintained in the client's file.

- Preadmission History and Physical Information for Healthy Options clients receiving outpatient hospital treatment:

  ✓ Clients enrolled in a managed health care plan may have a History and Physical (H&P) for a dental hospital admission by any provider with admitting privileges to the hospital where the dental treatment will be provided.

  ✓ Physician claims for H&Ps are to be billed to MAA as fee-for-service and require the appropriate ICD-9-CM dental diagnosis code on the HCFA-1500 claim form. State that the procedure is an H&P for dental admission to a short stay unit. Billers must put this in the *Remarks/Comments* field.

2. Inpatient

Nonemergent oral surgeries performed in an inpatient setting are generally a noncovered service. Exceptions to this policy are evaluated for DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting, e.g., orthognathic cleft palate bone grafting. Exceptions require prior written authorization for the inpatient hospitalization.

Assistant Surgeon

Assistant surgeons will be reimbursed at 20 percent of the maximum allowance for those procedures indicating "**Yes**" in the *Assistant Surgeon Allowed* column of the fee schedule. State in the description of service area on the claim form (field 59 – "Description" area) if assistant at surgery.

Oral Surgery

A. Global surgery reimbursement includes the provision of the following services:

- The operation;
- Preoperative visits, in or out of the hospital, beginning on the day prior to surgery;
- Services by the primary surgeon, in or out of the hospital, during a standard 90-day postoperative period (0 to 10 days for minor surgery);
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; and
- All additional medical or surgical services required.

B. When surgical procedure(s) are carried out within the listed period for follow-up care of a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

C. When multiple surgical procedures are performed on the same client and at the same operative session, total payment equals the sum of 100% of the global fee for the highest value procedure. Reimbursement for the second through the fifth surgical procedures will be 50% of the global fee for each procedure code.

To expedite payment of your claim, bill all the surgeries for the same operative session on the same claim form. Use the American Dental Association claim form, not the HCFA-1500 claim form.

POSTOPERATIVE VISITS ARE INCLUDED IN THE SURGICAL FEE.

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	

Oral Surgery – Oral Surgeons
Integumentary System

Excision – Debridement

				NFS	FS
11044	Debride tissue/muscle/bone. **[MAA's reimbursement is limited to cysts 5 mm or greater.]**	10	No	$150.83	$117.62

Biopsy

11100	Biopsy of skin lesion.	Zero	No	53.23	27.75
11101	Biopsy skin add-on	Zero	No	25.93	14.11

Excision – Benign Lesions

11440	Removal of skin lesion; 0.5 cm or less	10	No	79.40	39.59
11441	0.6 to 1.0 cm	10	No	95.32	55.28
11442	1.1 to 2.0 cm	10	No	111.48	74.39
11443	2.1 to 3.0 cm	10	No	137.64	96.91
11444	3.1 to 4.0 cm	10	No	171.54	129.22
11446	over 4.0 cm	10	No	207.03	165.85

Excision – Malignant Lesions

11640	Removal of skin lesion; 0.5 cm or less	10	No	93.96	65.97
11641	0.6 to 1.0 cm	10	No	125.13	98.51
11642	1.1 to 2.0 cm	10	No	146.74	115.80
11643	2.1 to 3.0 cm	10	No	171.08	136.50
11644	3.1 to 4.0 cm	10	No	218.85	176.09
11646	over 4.0 cm	10	No	272.77	228.87

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS
Repair – Simple					
12001	Repair superficial wound(s); 2.5 cm or less	10	No	89.64	50.73
12002	2.6 cm to 7.5 cm	10	No	95.32	66.43
12004	7.6 cm to 12.5 cm	10	No	110.34	78.03
12005	12.6 cm to 20.0 cm	10	No	138.32	97.14
12011	2.5 cm or less	10	No	95.09	52.55
12013	2.6 cm to 5.0 cm	10	No	103.97	70.53
12014	5.1 cm to 7.5 cm	10	No	121.03	84.17
12015	7.6 cm to 12.5 cm	10	No	153.79	106.24
12016	12.6 cm to 20.0 cm	10	No	183.59	130.59
Repair – Intermediate					
12031	Layer closure of wound(s); 2.5 cm or less	10	No	101.92	69.61
12032	2.6 cm to 7.5 cm	10	No	123.53	89.64
12034	7.6 cm to 12.5 cm	10	No	141.28	104.20
12035	12.6 cm to 20.0 cm	10	No	156.07	122.40
12051	2.5 cm or less	10	No	129.90	92.82
12052	2.6 cm to 5.0 cm	10	No	134.45	99.19
12053	5.1 cm to 7.5 cm	10	No	147.42	111.25
12054	7.6 cm to 12.5 cm	10	No	163.35	121.94
12055	12.6 cm to 20.0 cm	10	No	209.30	158.11
Repair – Complex					
13131	Repair of wound or lesion; 1.1 cm to 2.5 cm	10	No	176.09	142.64
13132	2.6 cm to 7.5 cm	10	No	244.79	217.26
13133	Repair wound/lesion add on	90	No	80.53	77.12
13150	Repair of wound or lesion; ; 1.0 cm or less	10	No	210.21	154.25
13151	1.1 cm to 2.5 cm	10	No	221.81	178.59
13152	2.6 cm to 7.5 cm	10	No	282.10	244.56
13153	Repair wound/lesion add on	Zero	No	88.50	84.40
13160	Late closure of wound	90	No	405.86	405.86

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	Maximum Allowable (All Ages) FS
Adjacent Tissue Transfer or Rearrangement					
14040	Skin tissue rearrangement	90	No	374.92	330.78
Free Skin Grafts					
15120	Skin split graft	90	No	434.98	396.99

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	

Musculoskeletal System

General

Excision

				NFS	FS
20220	Bone biopsy, trocar/needle	Zero	No	143.78	98.28

Introduction or Removal

20520	Removal of foreign body	10	No	174.04	127.86
20605	Drain/inject, joint/bursa	Zero	No	34.35	25.03
20670	Removal of support implant	10	No	175.18	121.94
20680	Removal of support implant	90	No	199.52	199.52

Grafts

20902	Removal of bone for graft	90	Yes	393.80	393.80

Head

Incision

21010	Incision of jaw joint	90	No	404.27	404.27

Excision

21025	Excision of bone, lower jaw	90	No	410.64	401.54
21030	Removal of face bone lesion	90	No	281.87	269.82
21031	Remove exostosis, mandible	90	No	155.84	128.31
21032	Remove exostosis, maxilla	90	No	155.38	134.45
21034	Removal of face bone lesion	90	Yes	632.00	632.00
21040	Removal of jaw bone lesion	90	No	120.58	92.59
21041	Removal of jaw bone lesion	90	No	291.66	263.67
21044	Removal of jaw bone lesion	90	Yes	474.11	474.11
21045	Extensive jaw surgery	90	Yes	629.72	629.72
21050	Removal of jaw joint	90	No	531.67	531.67
21060	Remove jaw joint cartilage	90	Yes	494.58	494.58
21070	Remove coronoid process	90	No	342.84	342.84

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS
	Introduction or Removal				
21076	Prepare face/oral prosthesis	10	No	553.28	496.86
21077	Prepare face/oral prosthesis	90	No	1,391.85	1,249.66
21081	Prepare face/oral prosthesis	90	No	961.64	852.22
21100	Maxillofacial fixation	90	No	228.41	183.37
21110	Interdental fixation	90	No	242.97	225.22
21120	Reconstruction of chin	90	No	299.16	230.69
	Repair, Revision or Reconstruction				
21141	Reconstruct midface, lefort	90	Yes	682.27	682.27
21142	Reconstruct midface, lefort	90	Yes	761.44	761.44
21143	Reconstruct midface, lefort	90	Yes	714.58	714.58
21145	Reconstruct midface, lefort	90	Yes	755.07	755.07
21146	Reconstruct midface, lefort	90	Yes	771.23	771.23
21147	Reconstruct midface, lefort	90	Yes	794.66	794.66
21150	Reconstruct midface, lefort	90	Yes	983.03	983.03
21151	Reconstruct midface, lefort	90	Yes	1,163.21	1,163.21
21154	Reconstruct midface, lefort	90	Yes	1,257.62	1,257.62
21155	Reconstruct midface, lefort	90	Yes	1,406.86	1,406.86
21159	Reconstruct midface, lefort	90	Yes	1,573.85	1,573.85
21160	Reconstruct midface, lefort	90	Yes	1,822.50	1,822.50
21193	Reconstruc lwr jaw w/o graft	90	Yes	661.12	661.12
21194	Reconstruc lwr jaw w/o graft	90	Yes	757.35	757.35
21195	Reconst lwr jaw w/o fixation	90	Yes	693.65	693.65
21196	Reconst lwr jaw w/fixation	90	Yes	749.61	749.61
21198	Reconst lwr jaw segment	90	Yes	620.39	620.39
21206	Reconstuct upper jaw bone	90	Yes	551.23	551.23
21208	Augmentation of facial bones	90	No	452.50	444.99
21209	Reduction of facial bone	90	Yes	347.17	312.36
21210	Face bone graft	90	No	448.86	436.34
21215	Lower jaw bone graft	90	No	466.83	432.93
21230	Rib cartilage graft	90	No	509.14	509.14
21240	Reconstuction of jaw joint	90	Yes	607.88	607.88
21242	Reconstruction of jaw joint	90	Yes	566.02	566.02
21243	Reconstruction of jaw joint	90	Yes	822.19	822.19
	Fracture and/or Dislocation				
21300	Treatment of skull fracture	Zero	No	81.45	24.80
21310	Treatment of nose fracture	Zero	No	75.98	17.29

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	
	Fracture and/or Dislocation			**NFS**	**FS**
21315	Treatment of nose fracture	10	No	116.48	65.29
21320	Treatment of nose fracture	10	No	158.34	92.59
21325	Treatment of nose fracture	90	No	176.09	176.09
21330	Treatment of nose fracture	90	No	260.03	260.03
21335	Treatment of nose fracture	90	No	374.01	374.01
21336	Treat nasal septal fracture	90	No	268.68	268.68
21337	Treat nasal septal fracture	90	No	185.19	143.32
21338	Treat nasoethmoid fracture	90	No	287.10	287.10
21339	Treat nasoethmoid fracture	90	Yes	356.04	356.04
21340	Treatment of nose fracture	90	No	459.55	459.55
21343	Treatment of sinus fracture	90	Yes	528.48	528.48
21344	Treatment of sinus fracture	90	Yes	792.38	792.38
21345	Treat nose/jaw fracture	90	No	432.70	376.28
21346	Treat nose/jaw fracture	90	No	486.62	486.62
21347	Treat nose/jaw fracture	90	Yes	528.71	528.71
21348	Treat nose/jaw fracture	90	Yes	668.62	668.62
21355	Treat cheek bone fracture	10	No	179.50	148.33
21356	Treat cheek bone fracture	10	No	175.86	175.86
21360	Treat cheek bone fracture	90	Yes	286.65	286.65
21365	Treat cheek bone fracture	90	Yes	629.26	629.26
21366	Treat cheek bone fracture	90	Yes	753.48	753.48
21385	Treat eye socket fracture	90	Yes	402.45	402.45
21386	Treat eye socket fracture	90	Yes	413.59	413.59
21387	Treat eye socket fracture	90	Yes	428.84	428.84
21390	Treat eye socket fracture	90	Yes	441.35	441.35
21395	Treat eye socket fracture	90	Yes	517.33	517.33
21400	Treat eye socket fracture	90	No	109.43	57.79
21401	Treat eye socket fracture	90	Yes	179.27	163.35
21406	Treat eye socket fracture	90	Yes	333.97	333.97
21407	Treat eye socket fracture	90	Yes	389.48	389.48
21408	Treat eye socket fracture	90	Yes	537.36	537.36
21421	Treat mouth roof fracture	90	No	289.38	280.51
21422	Treat mouth roof fracture	90	Yes	381.97	381.97
21423	Treat mouth roof fracture	90	Yes	449.54	449.54
21431	Treat craniofacial fracture	90	Yes	363.09	363.09
21432	Treat craniofacial fracture	90	Yes	389.03	389.03
21433	Treat craniofacial fracture	90	Yes	1,012.15	1,012.15
21435	Treat craniofacial fracture	90	Yes	716.17	716.17

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS
	Fracture and/or Dislocation				
21436	Treat craniofacial fracture	90	Yes	1,041.04	1,041.04
21440	Treat dental ridge fracture	90	No	189.73	150.38
21445	Treat dental ridge fracture	90	Yes	295.07	246.84
21450	Treat lower jaw fracture	90	No	219.31	137.64
21451	Treat lower jaw fracture	90	No	265.04	257.07
21452	Treat lower jaw fracture	90	No	356.26	147.19
21453	Treat lower jaw fracture	90	No	301.89	287.33
21454	Treat lower jaw fracture	90	No	286.88	286.88
21461	Treat lower jaw fracture	90	Yes	388.34	385.16
21462	Treat lower jaw fracture	90	Yes	465.92	422.69
21465	Treat lower jaw fracture	90	Yes	476.61	476.61
21470	Treat lower jaw fracture	90	Yes	606.74	606.74
21480	Reset dislocated jaw	Zero	No	51.87	18.65
21485	Reset dislocated jaw	90	No	183.14	172.22
21490	Repair dislocated jaw	90	Yes	467.28	467.28
21493	Treat hyoid bone fracture	90	No	115.11	115.11
21494	Treat hyoid bone fracture	90	Yes	245.93	245.93
21495	Treat hyoid bone fracture	90	Yes	256.85	256.85
21497	Interdental wiring	90	No	199.97	179.95

Neck (Soft Tissues) and Thorax

	Excision				
21550	Biopsy of neck/chest	10	No	102.15	77.35

Endoscopy/Arthroscopy

29800	Jaw arthroscopy/surgery	90	No	370.14	370.14
29804	Jaw arthroscopy/surgery	90	Yes	395.85	395.85

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages)	

Respiratory System

Nose – Repair

				NFS	FS
30580	Repair upper jaw fistula	90	No	274.59	274.59
30600	Repair mouth/nose fistula **(This procedure must not be performed for a minimum of 7 days after surgery to allow for healing.)**	90	No	260.72	260.72

Accessory Sinuses – Incision

31000	Irrigation, maxillary sinus	10	No	83.27	42.54
31030	Exploration, maxillary sinus	90	No	252.30	248.43

Trachea – Incision

31603	Incision of windpipe	Zero	No	142.87	142.87

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS

Digestive System

Vestibule of Mouth

Incision

40800	Drainage of mouth lesion	10	No	74.16	38.90
40801	Drainage of mouth lesion	10	No	118.07	105.79
40806	Incision of lip fold	Zero	No	27.75	27.75

Excision, Destruction

40808	Biopsy of mouth lesion	10	No	71.44	71.44
40810	Excision of mouth lesion	10	No	93.27	87.81
40812	Excise/repair mouth lesion	10	No	122.85	122.40
40814	Excise/repair mouth lesion	90	No	175.40	175.40
40816	Excision of mouth lesion	90	No	186.78	186.78
40819	Excise lip or cheek fold	90	No	141.73	137.41

Repair

40830	Repair mouth laceration	10	No	99.19	99.19
40831	Repair mouth laceration	10	No	121.71	121.71

Tongue, Floor of Mouth

Incision

41000	Drainage of mouth lesion	10	No	85.99	66.43
41005	Drainage of mouth lesion	10	No	83.49	67.11
41006	Drainage of mouth lesion	90	No	159.70	152.88
41007	Drainage of mouth lesion	90	No	160.61	150.38
41008	Drainage of mouth lesion	90	No	164.94	154.25
41009	Drainage of mouth lesion	90	No	169.26	164.03
41010	Incision of tongue fold	10	No	106.93	106.93
41015	Drainage of mouth lesion	90	No	187.46	172.22
41016	Drainage of mouth lesion	90	No	195.65	179.72
41017	Drainage of mouth lesion	90	No	195.19	177.00
41018	Drainage of mouth lesion	90	No	222.04	209.98

Excision

41108	Biopsy of floor of mouth	10	No	79.85	79.85
41112	Excision of tongue lesion	90	No	146.97	146.97
41113	Excision of tongue lesion	90	No	156.29	156.29

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS
	Other Procedures				
41520	Reconstruction, tongue fold	90	No	135.14	135.14
	Dentalalveolar Structures				
	Incision				
41805	Removal foreign body, gum	10	No	77.35	77.35
	Excision				
41822	Excision of gum lesion	10	No	121.03	78.72
41823	Excision of gum lesion	90	No	160.84	153.79
41825	Excision of gum lesion	10	No	87.13	86.68
41826	Excision of gum lesion	10	No	116.25	116.25
41827	Excision of gum lesion	90	No	164.94	164.94
41828	Excision of gum lesion	10	No	144.01	130.36
41830	Removal of gum tissue	10	No	157.43	148.10
	Other Procedures				
41874	Repair tooth socket	90	No	139.46	129.90
	Palate, Uvula				
	Excision				
42106	Excision lesion, mouth roof	10	No	111.25	111.25
	Repair				
42180	Repair palate	10	No	135.36	111.48
42182	Repair palate	10	No	162.21	162.21
42200	Reconstruct cleft palate	90	Yes	512.33	512.33
42205	Reconstruct cleft palate	90	Yes	538.26	538.26
42210	Reconstruct cleft palate	90	Yes	612.20	612.20
42215	Reconstruct cleft palate	90	Yes	439.30	439.30
42220	Reconstruct cleft palate	90	Yes	322.82	322.82
42225	Reconstruct cleft palate	90	Yes	438.85	438.85
42226	Lengthening of palate	90	Yes	467.28	467.28
42227	Lengthening of palate	90	Yes	435.89	435.89
42235	Repair palate	90	Yes	322.14	322.14
42260	Repair nose to lip fistula	90	Yes	383.57	383.57
42280	Preparation, palate mold	10	No	69.84	50.51
42281	Insertion, palate prosthesis	10	No	82.13	82.13

CPT™ Procedure Code	Description	Follow-up Days	Assistant Surgeon Allowed?	Maximum Allowable (All Ages) NFS	FS
Salivary Gland and Ducts					
	Incision				
42330	Removal of salivary stone	10	No	117.16	80.08
42335	Removal of salivary stone	90	No	164.03	164.03
	Excision				
42408	Excision of salivary cyst	90	No	216.58	216.58
42440	Excise submaxillary gland	90	Yes	306.90	306.90
42450	Excise sublingual gland	90	No	210.89	210.89
	Repair				
42500	Repair salivary duct	90	No	220.45	219.54
42505	Repair salivary duct	90	No	285.28	285.28
	Other Procedures				
42600	Closure of salivary fistula	90	No	295.98	243.65
Nervous System					
64600	Injection treatment of nerve	10	No	151.29	130.13

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Orthodontics for Children

Table of Contents

Definitions

The following definitions are found in WAC 388-535A-0010 and apply to the Orthodontic section of this billing instruction.

Adult – For the general purposes of MAA's dental program, means a client 21 years of age and older. (MAA's payment structure changes at age 19, which affects specific program services provided to adults or children). [WAC 388-535-1050]

Appliance placement – The application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

Child –For the general purposes of the MAA Dental Program, means a client 20 years of age or younger. (MAA's payment structure changes at age 19, which affects specific program services provided to adults or children). [WAC 388-535-1050]

Cleft – The opening or fissue involving the dentition and supporting structures especially one occuring in utero. These can be:

1. Cleft lip; and/or
2. Cleft palate (involving the roof of the mouth); or
3. Facial clefts (e.g., macrostomia).

Comprehensive full orthodontic treatment – Utilizing fixed orthodontic appliances for the treatment of the permanent dentition leading to the improvement of a patient's severe handicapping carniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

Craniofacial anomalies – Abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

Craniofacial team – A Department of Health and Medical Assistance Administration recognized cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provider integrated case management, to promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

Dental dysplasia – An abnormality in the development of the teeth.

EPSDT – The department's Early and Periodic Screening, Diagnosis, and Treatment program for clients 20 years of age and younger as described in chapter 388-534 WAC.

Hemifacial microsomia – A developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face appears smaller sized).

Interceptive orthodontic treatment – Procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. It is an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

Limited transitional orthodontic treatment – Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

Malocclusion – The abnormal contact between the upper and lower teeth that interferes with the highest efficiency during the movements of the jaw that are essential to chewing.

Maxillofacial – Relating to the jaws and face.

Occlusion – The relation of the upper and lower teeth when in functional contact during jaw movement.

Orthodontics – Treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

Orthodontist – A dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the Department of Health.

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Orthodontics

Who is eligible? [Refer to WAC 388-535A-0020]

- MAA covers medically necessary orthodontic treatment for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate for children (20 years of age and younger) only whose Medical IDentification card lists one of the following medical program identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	CNP – Children's Health Insurance Program

- Eligible clients in department-designated border areas may receive the same orthodontic services as if provided in-state.

Who is NOT eligible? [Refer to WAC 388-535A-0020]

MAA does not cover orthodontic services for adults.

Who may provide and be reimbursed for orthodontic services? [Refer to WAC 388-535A-0030]

With prior approval from MAA when necessary, the following providers may furnish and be reimbursed for covered comprehensive full orthodontic treatment, interceptive orthodontic treatment, or limited orthodontic treatment to MAA clients:

- Dentists who specialize in orthodontics;
- Pediatric dentists who provide MAA-approved orthodontic services;
- General dentists who provide MAA-approved orthodontic services; and
- Oral surgeons who provide MAA-approved orthodontic services.

What is covered by MAA?

[Refer to WAC 388-535A-0040]

- Complex orthodontic treatment for severe handicapping medical needs is covered subject to the limits of this section; and

- Selected Evaluation and Management (E&M) procedure codes, as listed on pages K17 through K27, related to specific diagnoses listed on page K28.

Is written prior authorization required?

[Refer to WAC 388-535A-0050]

Yes! Orthodontic care for **severe handicapping malocclusions** must be prior authorized by MAA.

- Orthodontists may use the Expedited Prior Authorization (EPA) process for Severe Handicapping Malocclusions. See page 18 for the EPA process using the HLD (WA-Mod) Index Scale (pages 25/26).

- Dentists must submit a written request for prior authorization to MAA.

  Exception

  Prior authorization is <u>not required</u> for clients with cleft lip, cleft palate or craniofacial anomalies when the eligible client is being treated by an orthodontist who is a member of an MAA-recognized cleft lip, cleft palate or craniofacial anomaly case management team.

When MAA authorizes a service, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided. WAC 388-535A-0050(1)

What are MAA's criteria for orthodontic services?

To be eligible for orthodontic care, a client must be eligible for EPSDT and meet one of the following categories:

- A child with clefts (lip and/or palate) and congenital or acquired craniofacial anomalies, when case-managed by an MAA-recognized cleft lip, cleft palate, or craniofacial team for:

  - ✓ Cleft lip and palate, cleft palate or cleft lip with alveolar process involvement;
  - ✓ Craniofacial anomalies, including but not limited to:

    - ➢ Hemifacial microsomia;
    - ➢ Craniosynostosis syndromes;
    - ➢ Cleidocranial dysplasia;
    - ➢ Arthrogryposis;
    - ➢ Marfans syndrome; or
    - ➢ Other syndromes by MAA review.

  - ✓ Other diseases/dysplasia with significant facial growth impact, e.g., juvenile rheumatoid arthritis (JRA); or
  - ✓ Post traumatic, post radiation, or post burn jaw deformity;

  Note: MAA or the Office of Children with Special Health Care Needs (OCSHCN) does not require written prior authorization for services to a client with cleft palate and/or craniofacial anomalies when the client is case-managed by an MAA-recognized cleft palate and/or craniofacial team that has a Special Agreement with MAA.

- A child with severe malocclusions which include one or more of the following:

  - ✓ Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE.
  - ✓ Crossbite of individual anterior teeth WHEN DESTRUCTION OF THE SOFT TISSUE IS PRESENT.
  - ✓ Severe traumatic deviations (for example: loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology).
  - ✓ Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties.
  - ✓ Other conditions from 5→12 on the handicapping labiolingual deviation HLD WA-Mod Index Scale that total 25 or higher.

Orthodontic treatment

[Refer to WAC 388-535A-0060]

MAA's payment includes the initial necessary retainers and appliance removal. MAA does not cover lost or broken orthodontic appliances.

- MAA covers interceptive orthodontic treatment once in a client's lifetime for clients with cleft palate, craniofacial anomaly, or severe malocclusions.

- MAA covers limited transitional orthodontic care for a maximum of one year from original placement. MAA allows follow up treatments in three-month increments after the initial appliance placement.

- MAA limits full orthodontic care to a maximum of two years from original appliance placement. MAA allows six follow-up treatments in three-month increments, beginning six months after original appliance placement. MAA may allow, with written prior authorization, two additional follow-up treatments for clients who have not had limited transitional orthodontic treatment. See "When Do I Bill"" pg. K10.

What about orthodontic treatment beyond the client's eligibility period?

[Refer to WAC 388-535A-0060(10)(11)]

MAA requires written prior authorization for orthodontic care, unless specified otherwise. Frequently, orthodontic care extends over many months. Make certain that the client or the client's guardian fully understands that if eligibility for dental benefits ends before the conclusion of the orthodontic treatment, payment for any remaining treatments will be his/her responsibility.

When do I need to fill out the Orthodontic Information Sheet?

Any time orthodontic services are requested for an MAA client, you must complete the Orthodontic Information sheet. See page K5 for instructions on filling out the Orthodontic Information sheet and submittng any necessary photos. Use the **REVISED** Orthodontic Information Sheet, **page K7/8. Copy and use as necessary.**

Orthodontic Information Sheet [DSHS form 13-666]

(To be completed by the performing orthodontist or dentist. Use either blue or black ink only and a highlighter to prevent return of claims by Claims Processing.)

Follow steps 1 and 2 below when applying for authorization to provide orthodontic services:

1. Complete the Orthodontic Information sheet [current version dated 6/2001]

a) Fill in the *provider information* and *patient information* sections at the top of the sheet.

b) In Part 1, fill in the information requested in each area that applies to the treatment being provided.

c) In Part 2, fill in as much as possible to assist MAA's orthodontic consultant in determining medical necessity.

2. Submit the following full set of 8 dental photographs to MAA:

a) **Intraoral Dental Photographs:**

1) Anterior (teeth in centric occlusion)
2) Right lateral (teeth in centric occlusion)
3) Left lateral (teeth in centric occlusion)
4) Upper Occlusal View (taken using a mirror)
5) Lower Occlusal View (taken using a mirror)

b) **Extraoral Photographs:**

1) Frontal
2) Frontal Smiling
3) Lateral Profile

Mailing Address:

Mail the materials, with the patient's PIC and name, to:

Quality Utilization Section – Dental
PO Box 45506
Olympia, WA 98504-5506

Remember to include the authorization number on the ADA claim form whenever authorization has been obtained.

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See next page for
Orthodontic Information Sheet

ORTHODONTIC INFORMATION

MEDICAL ASSISTANCE ADMINISTRATION/DIVISION OF HEALTH SERVICES QUALITY SUPPORT
QUALITY UTILIZATION SECTION -ORTHO
OLYMPIA WA 98504-5506

Both Sides Of This Form Must be Completed and Submitted BEFORE Treatment.

Provider name and address:	PATIENT'S NAME LAST	FIRST	MI	SEX

PATIENT IDENTIFICATION CODE (PIC)				
FI	MI	BIRTHDATE	LAST NAME	TB

DSHS Provider number:

PART I. TREATMENT REQUESTED (Check box below)

DATE REQUESTED:

- ☐ Maxillo-facial cleft deformity
- ☐ Full Treatment
- ☐ Transfer case
- ☐ Interceptive treatment
- ☐ Limited Transitional Treatment (mid-late mixed dentition)
- ☐ Special Review
- ☐ Advisory (If there is no request for treatment or appliances stop here)

☐ PREVIOUS TREATMENT PLAN?

ESTIMATED START DATE

TENTATIVE TREATMENT PLAN:

FUNCTIONAL CONCERNS:

TREATMENT PLAN (Following Case Study):

(There should be no other equally effective, more conservative and substantially less costly treatment available.)

THIS SECTION FOR MAA/DUS USE ONLY

☐ **Orthodontic case study and treatment request are authorized.**

☐ **Orthodontic case study request authorized. Requested treatment is not authorized at this time.** ***Submit case study for evaluation.***

☐ **APPROVED** ☐ **DENIED** ☐ **PENDED**

Refer to the cover sheet for the consultant's comments

Authorization Number:	
Orthodontic Consultant	Date

The authorization number must be entered on all billings and extension requests.

RETAIN this information sheet with case record.

RETURN a copy of this form to Orthodontic Authorization, QUS - Dental (address at top of form) with request(s) for extension of authorization.

Direct Authorization Questions to (360) 725-1671

DSHS 13-666 (REV. 06/2001)

ORTHODONTIC DIAGNOSTIC INFORMATION

Part II

Client Name:

Client Age:

Client's Chief Complaint:

STAGE OF DENTITION:

☐ Primary ☐ Permanent ☐ Mixed

ANTERIOR TEETH:

Overjet _____ mm

Overbite _____ mm

Open bite _____ mm

Midline _____ mm

Corset _____

POSTERIOR TEETH:

Angle Classification:

Skeletal Classification: (Circle One)

Class 1 Class 2 Class 3

Dental Classification: (Circle One)

Right: Class 1 E to E Class 2 Class 3

Left: Class 1 E to E Class 2 Class 3

Cross bite:

Indicate all teeth involved _____

CROWDING (Approximate) SPACING

mm		mm	
mm		mm	

MISSING & MALPOSED TEETH (List)

	Yes	?
Ectopic Eruption (Numbers of teeth excluding 3rd Molar(s): _____		
Missing: _____		
Malposed, Inclined, or Rotated: _____		
Impacted _____		
Ankylosed _____		
Supernumerary _____		
Malformed _____		

BRIEF INITIAL OPINIONS

HABITS?

MUSCULATURE: TONE & FUNCTION:

SYMMETRY of ARCHES?

TEMPOROMANDIBULAR DYSFUNCTION?

GOOD ORAL HYGIENE?

☐ Good ☐ Fair ☐ Poor

RESTORATION OR CARIES PROBLEMS?

OTHER MEDICAL or DENTAL PROBLEMS?

I certify that the information provided is true and accurate to the best of my knowledge.

PROVIDER SIGNATURE	DATE

Orthodontic Examination Review Results from MAA

The MAA orthodontic consultant will review the photos and all of the information you submit for each case and will return the *Orthodontic Information* sheet to you with one of the following indications:

____ Orthodontic case study and treatment requests are authorized.

____ Orthodontic case study request authorized. *Requested treatment is not authorized at this time*. Re-submit with study models for evaluation, or see comments on the purple "Orthodontic Authorizations" Sheet.

____ Request for orthodontic case study denied. See comments on the purple "Orthodontic Authorizations" Sheet.

Submitting Additional Information

If your initial submission is not authorized for treatment, submit only the information requested by MAA for re-evaluation. Such information may include:

- Claim for the full case study attached to the Orthodontic Information sheet; and
- Appropriate X-rays, e.g., panoramic and cephalometric radiographs.
- Photographs (8). See page K5.
- **A separate letter with any additional medical information if it will contribute information that may affect MAA's final decision.**
- **Study models. (Do not send study models unless they are requested.)**
- **Other information if requested.**

When do I bill?

Limited Orthodontic Treatment

1. **First Billing:** When limited orthodontic treatment is authorized, you should bill MAA at the time you place the appliance. The initial reimbursement will include placement of the appliance and the first quarter of active treatment.

2. **Subsequent Billing:**

   - ✓ After the original three months of treatment, you must bill subsequent treatments in three-month segments.
   - ✓ **Services must be billed at the end of the three-month period.** For billing purposes, use a date towards the end of the three-month period as the date of service.
   - ✓ Services billed using earlier dates in the three-month period may be denied payment.
   - ✓ Document the actual service dates in the client's record.

3. **Total Care Maximum:** MAA reimburses up to one year of total care from the date of the original placing of appliances. MAA does not authorize extensions for limited transitional orthodontic treatment.

Full Orthodontic Treatment

1. **First Billing:** When full orthodontic treatment is authorized, you should bill MAA at the time of the placing of the appliance. **The initial reimbursement includes placement of the appliance(s) and the first six (6) months of active treatment.**

2. **Subsequent Billing:**

   - ✓ After the original six months of treatment, you must bill subsequent treatments in three-month segments.
   - ✓ Services must be billed at the end of the three-month period, using a date towards the end of the three-month period as the date of service for billing purposes.
   - ✓ Services billed using earlier dates in the three-month period may be denied payment.
   - ✓ Document the actual service dates in the client's record.
   - ✓ Indicate the date of the original appliance placement in field 35 of the ADA claim form.

3. **Total Care Maximum:** MAA reimburses a maximum of two years of total care from the date of the original appliance placement, unless the client has reached age 21 or no longer eligible for orthodontic coverage. Full orthodontic treatment for clients who have had no limited transitional orthodontic care may be extended with prior written authorization as long as they continue to be eligible for orthodontic coverage.

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs

Orthodontic

Clinical Evaluations

0803D	**Orthodontic consultation** Billable only by an orthodontist. This visit involves a referral from a client's general dentist to an orthodontic specialist. Allowed once per provider, per client.	No	$36.00
0804D	**Orthodontic information (initial workup)** Includes orthodontic oral examination, taking and processing clinical photographs, completing required form(s) and obtaining MAA's authorization decision.	No	$45.00
0806D	**Orthodontic Case Study for cleft palate and craniofacial anomaly cases**. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference. **Prior Authorization** • **Prior authorization is required, if treating provider is not a member of a recognized craniofacial team.** • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team.	See Descrp	$200.00
0807D	**Orthodontic Case Study for severe handicapping malocclusion cases** Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment plan from such records, and formal case conference.	Yes	$190.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs

Interceptive Orthodontics

0836D	**Interceptive orthodontic treatment for cleft palate and craniofacial anomaly cases.** Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	No	$520.00
0837D	**Interceptive orthodontic treatment for severe malocclusion cases.** Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.	Yes	$330.00

Limited Transitional Orthodontic Treatment

0840D	**Initial placement of appliance(s) for cleft palate and craniofacial anomaly cases.** Includes first 3 months of treatment and appliance(s).	No	$670.00
0841D	**Initial placement of appliance(s) for severe malocclusion cases.** Includes first 3 months of treatment and appliance(s).	Yes	$420.00

For the following two codes (0843D and 0844D) to be billed:

- The provider must examine the client in the provider's office at least once during the 3-month period.
- Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service.
- Services billed using earlier dates in the 3-month period may be denied payment.
- Actual service dates must be documented in the client's record.

0843D	**Each additional 3 months of limited transitional orthodontic treatment for cleft palate and craniofacial anomaly cases.** Maximum of 3 units allowed.	No	$210.00
0844D	**Each additional 3 months of limited transitional orthodontic treatment for severe malocclusion cases.** Maximum of 3 units allowed.	Yes	$180.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs

Full Orthodontic Treatments

0866D	**Initial placement of appliance(s) for a client with a cleft or craniofacial anomaly** who HAS HAD limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s). **Prior Authorization** • **Prior authorization is required, if treating provider is not a member of a recognized craniofacial team.** • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team.	See Descrp	$1,400.00
0867D	**Each additional 3 months of full orthodontic treatment for a client with a cleft or craniofacial anomaly** who HAS HAD limited transitional treatment. Maximum of 6 units allowed. **For this service:** • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. **Prior Authorization** • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team.	See Descrp	$280.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs
0868D	**Initial placement of appliance(s) for a client with a cleft or craniofacial anomaly** who HAS NOT previously received limited transitional orthodontic treatment. Includes first 6 months of treatment and appliances. **Prior Authorization** • **Prior authorization is required, if treating provider is not a member of a recognized craniofacial team.** • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team.	See Descrp	$1,800.00
0869D	**Each additional 3 months of full orthodontic treatment for a cleft or craniofacial anomaly** client who HAS NOT previously received limited transitional treatment. Maximum of 6 units allowed. Two additional units may be allowed with prior authorization. **For this service:** • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record. **Prior Authorization** • Prior authorization is required, if treating provider is not a member of a recognized craniofacial team. • Prior authorization is not required, if treating provider is a member of a recognized craniofacial team.	See Descrp	$450.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs
0870D	**Initial placement of appliance(s) for a client with severe malocclusion**, who HAS HAD limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s).	Yes	$1,100.00
0871D	**Each additional 3 months of full orthodontic treatment for a client with severe malocclusion,** who HAS HAD limited transitional treatment**.** Maximum of 6 units allowed. **For this service:** • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record.	Yes	$125.00
0872D	**Initial placement of appliance(s) for a client with severe malocclusion,** who HAS NOT previously received limited transitional orthodontic treatment. Includes first 6 months of treatment and appliance(s).	Yes	$1,200.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs
0873D	**Each additional 3 months of full orthodontic treatment for a client with severe malocclusion**, who HAS NOT previously received limited transitional treatment. Maximum of 6 units allowed. Two additional units may be allowed with prior authorization. **For this service:** • The provider must examine the client in the provider's office at least once during the 3-month period. • Services must be billed at the end of the 3-month period. For billing purposes, use a date towards the end of the 3-month period as the date of service. • Services billed using earlier dates in the 3-month period may be denied payment. • Actual service dates must be documented in the client's record.	Yes	$225.00
0874D	**Brace removal and provision of permanent retainer**, for a client whose appliance was placed by an orthodontic provider not participating with MAA, and/or whose treatment was previously covered by another third-party payor. Fee includes debanding and removal of cement.	Yes	$100.00

State-Unique Code	Description	Prior Auth?	Maximum Allowable 0-20 yrs
0875D	**Each three-month period of follow-up orthodontic care** for a client who meets the criteria in WAC 388-535-1250, but whose banding, appliance placement and/or initial follow-up care was done by a provider not participating with MAA, or whose treatment was authorized and previously covered by another third-party payor. This follow-up care is for a period not to exceed one year, or the length of time remaining under the treatment plan authorized by the previous payor, whichever is shorter. One **unit** allowed every 3 months, up to a total of 4 units.	Yes	$120.00

Radiographs

D0330	**Panoramic film – maxilla and mandible** Allowable for oral surgical and orthodontic purposes only. Not to be used for restoration diagnostic purposes. Documentation must be entered in the client's file. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 3-year period. A shorter interval between panoramic–type x-rays may be allowed for: • Emergent services, with authorization from MAA within 72 hours of the service; • Oral surgical and orthodontic services, with written prior authorization from MAA; or • Preoperative or postoperative surgery cases. Preoperative xrays must be provided within 14 days prior to surgery, and postoperative x-rays must be provided within 30 days after surgery. **Doing <u>both</u> a panoramic film and an intraoral complete series is not allowed.**	No	$43.00

Expedited Prior Authorization for Severe Handicapping Malocclusions *(for use by Orthodontists only)*

- ✓ EPA for severe handicapping malocclusions is limited to orthodontists
- ✓ EPA is appropriate only when the client meets one of specified EPA criteria1→4 or the client's index score is an index level of 30 or higher when using the HLD (WA-Mod) Index Scale.

  Note: When the client's score is an index level less than 30, orthodontists must submit an Orthodontic Information sheet to MAA for prior authorization (PA) review.

- ✓ MAA coverage is limited to complex orthodontic treatment for severe handicapping medical needs subject to the limits within WAC 388-535A-0040.
- ✓ All orthodontic services are subject to MAA review and all current regulations apply,

Why should I use expedited prior authorization?

The EPA process is designed to determine if the HLD (WA-Mod) index scale can be used statewide and maintain the current client coverage level. This process will reduce the need for written copy prior to authorization. The intent is to establish authorization criteria based on the HLD (WA- Mod) Index Scale with specific procedure codes, enabling orthodontists to create an EPA number when appropriate. **MAA will be use the EPA process for procedure codes and specified criteria.**

By using this EPA number, the provider verifies that the specified criteria have been met for the requested service.

- If specified EPA criteria are **not** met, a written request for prior authorization must be submitted.
- All general dental providers must continue to send in hard copy requests for prior authorization**.**
- If you have already obtained an authorization number from MAA for an orthodontic case, continue to use that authorization number rather than build an EPA number.

  Note: Cleft palate is not a part of this evaluation process. Written prior authorization is not required by MAA or Children with Special Health Care Needs (CSHCN) for cleft palate treatment when the client is case-managed by a department-recognized cleft palate and/or craniofacial team.

EPA Billing

Use the same EPA number when separately billing each additional 3 months on subsequent claims.

What are the criteria for expedited prior authorization?

EPA Criteria:

#1. Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE.

#2. Crossbite of individual anterior teeth WHEN DESTRUCTION OF THE SOFT TSSUE IS PRESENT.

#3. Severe traumatic deviations (For example: loss of a premaxilla segment by burns or by accident; the result of osteomyelitis, or other gross pathology).

#4. Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties.

#5. Other conditions from 5→12 on the HLD WA-Mod Index Scale that total 30 or higher.

Orthodontists who determine one of the following when using the HLD (WA-Mod_) Index Scale may use the EPA process:

- A client meets criterion 1, 2, 3, or 4 above; or
- A client scores at an index level of 30 or higher (criterion 5)

Medical Justification

1. All information pertaining to medical necessity must come from the client's **prescribing orthodontist.** Information obtained from the client or someone on behalf of the client (e.g., family) will not be accepted.

2. Measurement, counting, recording, or consideration for treatment is performed only on teeth that have erupted and can be seen on the diagnostic study models. All measurements are made or judged on the basis equal to, or greater than, the minimum requirement.

3. Only permanent natural teeth will be considered for evaluation of severe malocclusions.

4. Use either of the upper central incisors when measuring overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. The upper lateral incisors or upper canines may not be used for these measurements.

5. Impacted teeth alone are not considered a severe handicapping malocclusion.

Documentation

The billing provider must keep documentation of the criteria in the client's file. This documentation must be readily available for review by MAA staff on request.

Please note:
Upon audit, if specified criteria are not met,
MAA has the authority to recoup any payments made
Based on RCW 74.02.050; 74.08.090; 74.09.290; WAC 388-502-0020;
WAC 388-502-0230; and the Core Provider Agreement

How do I create an expedited prior authorization number?

To bill MAA for orthodontic procedures that meet the EPA criteria listed on the following pages, the provider must **create a 9-digit EPA number.**

Creating your EPA number

1. The first six digits of the EPA number must be: **870000_ _ _ .**
2. Choose the 7th and 8th digits from the **EPA number column** according to the specific orthodontic service and coordinating procedure code.
3. Choose the 9th digit from **EPA criterion 1, 2, 3, 4, or 5.**

Enter the authorization number on the ADA claim form in field 2 or in the *Authorization* or *Comments* field when billing electronically.

Example 1:

The 9-digit EPA number for *full orthodontic treatment* for a client who has had limited transitional Tx and meets specified criterion #3 (severe traumatic deviations) would be **870000953.**

- **870000** = first six digits of all EPA numbers;
- **95** = the 7th and 8th digits of an EPA number, indicated for the requested orthodontic procedure;
- **3** = the 9th digit of an EPA number representing the specific criterion met.

Example 2:

The 9-digit EPA number for *full orthodontic treatment* for a client who has not had limited transitional Tx and meets specified criterion #5 (other conditions from 5→12 on the HLD (WA-Mod) Index Scale that total 30 or higher) would be **870000965.**

- **870000** = first six digits of all EPA numbers;
- **96** = the 7th and 8th digits of an EPA number, indicated for the requested orthodontic procedure;
- **5** = the 9th digit of an EPA number representing the specific criterion met.

EPA Number, Procedure Code & Description For Severe Handicapping Malocclusion	
The first 6 digits of the EPA number MUST BE: 870000	
7th & 8th Digits EPA #	**Procedure Code and Description**
95	**FULL ORTHODONTIC TREATMENT OF THE PERMANENT DENTITION** **A maximum of two years total care from the date of the original banding will be reimbursed, unless the client has reached age 19 and is no longer eligible. No additional reimbursement for treatment extending beyond two years.** **0807D** Orthodontic Case Study for Severe Handicapping Malocclusion. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and treatment (Tx) plan from such records, and formal case conference. **0870D** Banding and initial placement of appliance(s) for a client with severe malocclusion, who **HAS HAD** limited transitional orthodontic Tx. Includes first 6 months of Tx and appliances(s). **0871D** Each additional 3 months of full orthodontic Tx for a client with severe malocclusion who **HAS HAD** limited transitional Tx. **Maximum of 6 units allowed.***
96	**0807D** Orthodontic Case Study for Severe Handicapping Malocclusion. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and Tx plan from such records, and formal case conference. **0872D** Banding and initial placement of appliance(s) for a client with severe malocclusion, who **HAS NOT** previously received limited transitional orthodontic Tx. Includes first 6 months of Tx and appliances(s). **0873D** Each additional 3 months of full orthodontic Tx for a client with severe malocclusion, who **HAS NOT HAD** limited transitional Tx. **Maximum of 6 units allowed.***

***** For this service to be billable, the provider must examine the client in the provider's office at least once during the 3-month Tx period. The service must be billed at the end of the 3-month period, using a date toward the end of the 3-month period as the date of service for billing purposes. Services billed using earlier dates in the 3-month period may be denied payment. Actual service dates must be documented in the client's record.

The first 6 digits of the EPA number MUST BE: 870000	
7th& 8th Digits EPA #	**Procedure Code and Description**
	LIMITED TRANSITIONAL ORTHODONTIC TREATMENT & ORTHODONTIC CASE STUDY **MAA will reimburse up to one year of total care from the date of the original placing of appliances. MAA will not authorize extensions for limited transitional orthodontic treatment beyond what was previously requested and authorized. The provider is required to finish Tx regardless of the length of time involved beyond the 12 months reimbursed by MAA**. MAA's payment includes all care during Tx, the necessary retention appliances, equilibration, observation and follow-up care for an average of a year, and appliance removal. **No allowance given for lost or broken appliances.**
97	**0807D** Orthodontic Case Study for Severe Handicapping Malocclusion. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and Tx plan from such records, and formal case conference. **0841D** Initial placement of appliance(s) for severe handicapping malocclusion cases. Includes first three (3) months of Tx and appliance(s). **0844D** Each additional 3 months of limited transitional orthodontic Tx. **Maximum of 3 units allowed.***
98	**INTERCEPTIVE ORTHODONTICS** **0807D** Orthodontic Case Study for Severe Malocclusion. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination), formation of diagnosis and Tx plan from such records, and formal case conference. **0837D** Interceptive orthodontic Tx for severe malocclusion cases. Payable only once per client. The allowance includes all professional fees, laboratory costs, and required follow-up. **No allowance given for lost or broken appliances.**

***** For this service to be billable, the provider must examine the client in the provider's office at least once during the 3-month Tx period. The service must be billed at the end of the 3-month period, using a date toward the end of the 3-month period as the date of service for billing purposes. Services billed using earlier dates in the 3-month period may be denied payment. Actual service dates must be documented in the client's record.

The first 6 digits of the EPA number MUST BE: 870000 The 7th & 8th digits are picked from previous 2 pages.	
9th Digit of EPA #	**EPA Criterion**
1	Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE.
2	Crossbite of individual anterior teeth WHEN DESTRUCTION OF THE SOFT TISSUE IS PRESENT.
3	Severe traumatic deviations (For example: loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology).
4	Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties.
5	Other conditions from 5→12 on the HLD WA-Mod Index Scale that total 30 or higher.

NOTE:

This **Handicapping Labiolingual Deviation (HLD) Index Scale, Washington Modified (WA-Mod)** process is similar to the CalMod HLD index developed in 1998 by William S. Parker, from Sacramento, California. For your reference, a "special article" on the CalMod HLD Index is in the August 1998 American Journal of Orthodontics and Dentofacial Orthopedics; 114:134-41.

HANDICAPPING LABIOLINGUAL DEVIATION (HLD) INDEX

(You will need this score sheet and a Boley Gauge or a disposable ruler.)

Orthodontist Name: _____ Provider #: _____

Client Name: _____ Patient PIC #: _ _ _ _ _ _ _ _ _ _ _ _ _

Procedure: *(To be completed by the Orthodontist)*

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- If anterior crowding and an ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition.
- The use of a recorder (hygienist, assistant or additional staff person) is recommended.

	Conditions	HLD Score
1.	Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE** (Indicate an "X" if present and score no further.)	
2.	Crossbite of individual anterior teeth **WHEN DESTRUCTION OF THE SOFT TISSUE IS PRESENT** (Indicate an "X" if present and score no further.)	
3.	Severe traumatic deviations (Retain description of condition in client's file. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) (Indicate an "X" if present and score no further.)	
4.	Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties (Indicate an "X" if present and score no further.)	
5.	Overjet in mm.	
6.	Overbite in mm.	
7.	Mandibular protrusion, in mm. _____ x 5 =	
8.	Open bite, in mm. _____ x 4 =	

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE <u>ONLY THE MOST SEVERE CONDITION</u>. DO NOT SCORE BOTH CONDITIONS.

9.	Ectopic eruption: Count each tooth excluding 3rd molar (s) _____ x 3 =	
10.	Anterior crowding: Score one point for MAXILLA, and/or one point for MANDIBLE; two points maximum for anterior crowding _____ x 5 =	
11.	Labiolingual spread, in mm	
12.	Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar). If present: Score 4	
	Total Score	

If a client <u>does not meet</u> EPA criterion 1, 2, 3, or 4 OR <u>does not score</u> 30 or above, you must submit a hard copy request.

HANDICAPPING LABIOLINGUAL INDEX (WA-Mod)
SCORING INSTRUCTIONS FOR SEVERE MALOCLUSIONS

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose "malocclusion." All measurement are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering "O" (refer to scoresheet).

The following information should help clarify the categories on the **HLD Index:**

1. **Deep Impinging Overbite:** Indicate an "X" on the scoresheet when lower incisors are destroying the soft tissue of the palate. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion, and no further scoring is necessary.

2. **Crossbite of Individual Anterior Teeth:** Indicate an "X" on the scoresheet when destruction of soft tissue is present. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion and no further scoring is necessary.

3. **Severe Traumatic Deviations:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology. Indicate with an "X" on the scoresheet and attach documentation and description of condition. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion, and no further scoring is necessary.

4. **Overjet greater than 9 mm:** If the overjet is greater than 9 mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5mm with reported masticatory and speech difficulties, indicate an "X" and score no further. If the reverse overjet is not greater than 3.5 mm, score under #7.

5. **Overjet in Millimeters:** This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the scoresheet.

6. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the scoresheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

7. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the scoresheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."

8. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. The measurement is entered on the scoresheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

9. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the scoresheet and multiply by three (3). If condition #10, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. **DO NOT SCORE BOTH CONDITIONS.**

   The customary and accepted conditions of dental ectopia include ectopic eruption such as that when a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar. These include transposed teeth. Also included are teeth in the maxillary sinus, in the ascending ramus of the mandible and other such situations, when teeth develop in other locations, rather than in the dental arches. These are classic textbook examples of ectopic eruption and development of teeth. In all other situations, teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Regarding mutually blocked out teeth, only one will be counted.

10. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points each for maxillary and mandibular anterior crowding. If condition #9, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS.

11. **Labiolingual Spread**: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch In the advent that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, but only the most severe individual measurement should be entered on the index.

12. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the scoresheet.

Billing for Evaluation and Management Procedure Codes

Only orthodontists may bill the following Evaluation and Management (E&M) procedure codes using the criteria listed below:

- Only one orthodontic provider, participating as an active member of the craniofacial team, may bill for any one of these E&M procedure codes per client, per visit.
- **E&M procedure codes must be billed on the American Dental Association (ADA) claim form and cannot be billed in combination with periodic/limited/comprehensive oral evaluations.** The qualifying diagnosis code(s) (see list on page 28) must be kept in the client's record.
- **Facility setting maximum allowable fees** (FS MAF) – Paid by MAA when the provider performs the services in a facility setting and cost of the resources are the responsibility of the facility; or
- **Non-facility setting maximum allowable fees** (NFS MAF) – Paid by MAA when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Evaluation and Management Codes Billable Only by Orthodontists On MAA-recognized Craniofacial Teams			
CPT Code	**Brief Description**	**NFS**	**FS**
99201	Office/outpatient visit, new	$33.48	$22.08
99202	Office/outpatient visit, new	60.20	44.17
99203	Office/outpatient visit, new	89.76	67.32
99204	Office outpatient visit, new	127.52	99.74
99205	Office/outpatient visit, new	162.07	132.86
99211	Office/outpatient visit, est.	19.95	8.55
99212	Office/outpatient visit, est.	35.62	22.44
99213	Office/outpatient visit, est.	49.16	33.13
99214	Office/outpatient visit, est.	77.30	54.50
99215	Office/outpatient visit, est.	113.27	87.98
99241	Office consultation	29.35	20.70
99242	Office consultation	54.37	42.09
99243	Office consultation	72.34	55.96
99244	Office consultation	102.38	82.81
99245	Office consultation	132.63	109.88

Related Diagnosis Codes on next page ☞

Related Diagnosis Codes

The E&M procedure codes listed on page 27 may be billed only for clients with any of the diagnosis codes listed on this page. The qualifying diagnosis code(s) must be kept in the client's record:

Dx Code	Description
213.1	Benign neoplasm of lower jaw bone
744.9	Unspecified anomalies of face and neck
749.0	Cleft palate
749.00	Cleft palate, unspecified
749.01	Unilateral, complete
749.02	Unilateral, incomplete (cleft uvula)
749.03	Bilateral, complete
749.04	Bilateral, incomplete
749.10	Cleft lip, unspecified
749.11	Unilateral, complete
749.12	Unilateral, incomplete
749.13	Bilateral, complete
749.14	Bilateral, incomplete
749.2	Cleft palate with cleft lip
749.20	Cleft palate with cleft lip, unspecified
749.21	Unilateral, complete
749.22	Unilateral, incomplete
749.23	Bilateral, complete
749.24	Bilateral, incomplete
749.25	Other combinations
754.0	Certain congenital musculoskeletal deformities of skull, face and jaw
755.55	Acrocephalosyndactyly
756.0	Anomalies of skull and face bones
802.2	Mandible, closed
802.21	Condylar process
802.22	Subcondylar
802.23	Coronoid process
802.24	Ramus, unspecified
802.25	Angle of jaw

Dx Code	Description
802.26	Symphysis of body
802.27	Alveolar border of body
802.28	Body, other and unspecified
802.29	Multiple sites
802.3	Mandible, open
802.31	Condylar process
802.32	Subcondylar
802.33	Coronoid process
802.34	Ramus, unspecified
802.35	Angle of jaw
802.36	Symphysis of body
802.37	Alveolar border of body
802.38	Body, other and unspecified
802.39	Multiple sites
802.4	Malar and maxillary bones, closed
802.5	Malar and maxillary bones, open
802.6	Orbital floor(blow-out), closed

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State of Washington
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
PO Box 9245, Olympia, WA 98507-9245

Change Service Requested